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ABSTRACT

This book of readings consists of 15 chapters grouped into 4 "Parts." The readings provide information and strategies for counselors, teachers, parents, administrators, social workers, and others who work with youth at risk. Sample programs that have been effective are described and data are provided on causal factors for youth problems. The book contains in-depth looks at such topics as teenage suicide, depression, drugs, eating disorders, gangs, dropping out of school, and sexual abuse. Part 1 presents information related to population identification, the issues and concepts involved, and a framework to aid the reader in better understanding the variables that relate to the at-risk population. Parts 2 and 3 present both causal factors and resultant behaviors that are descriptive of the at-risk population. Data are provided on both developmental and environmental factors that place an individual at risk and behaviors that are often the result of the causal factors identified. Part 4 presents information regarding one of the major results of at-risk behaviors - dropping out of the educational system. The final chapter of the book identifies both regional and national programs that have proven to be effective in working with at-risk populations. (NB)

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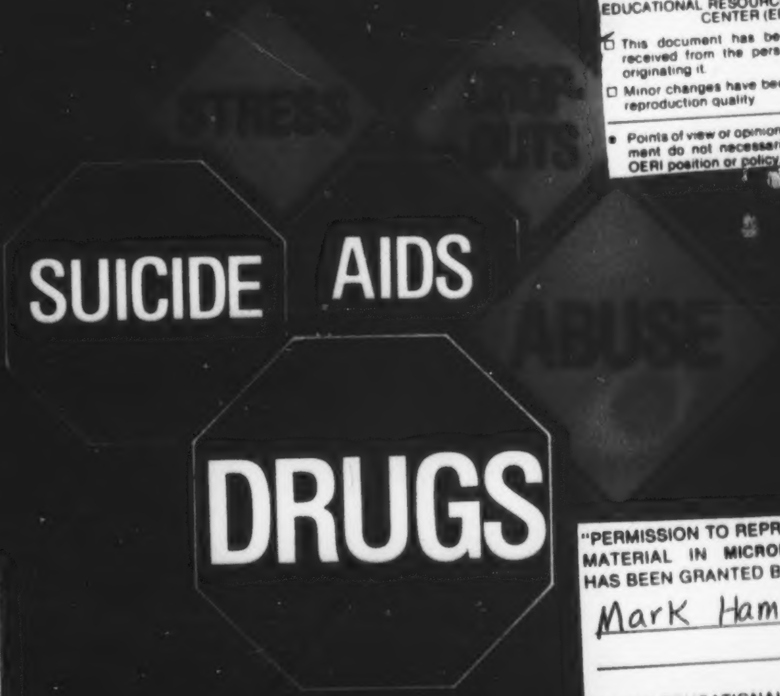

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Youth at Risk:

A Resource for Counselors, Teachers and Parents

Edited by Dave Capuzzi and Douglas R. Gross

American Association for
Counseling and Development
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TO: Kevin and Keith Capuzzi

Your supportiveness and quick wit made this book possible. You are wonderful role models, each in your own way, for other young people.

TO: Lola Gross

With love all is possible.

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PREFACE

This book is intended to provide information regarding "at-risk" youth for a wide population of helping professionals. Counselors, teachers, administrators, social workers, psychologists, and persons involved in the education of the helping professional should all benefit from the information contained in this text. It has been designed to include not only a review of the research in each of the areas addressed but also case illustrations, applicable techniques, intervention strategies, and samples of programs that have proven effective in working with an at-risk population.

The text is developmental in its orientation. Part 1 presents information related to population identification, the issues and concepts involved, and a framework to aid the reader in better understanding the myriad variables that relate to the at-risk population.

Parts 2 and 3 present both causal factors and resultant behaviors that are descriptive of the at-risk population. In these sections, the reader is provided with data related to both developmental and environmental factors that place an individual at risk and behaviors that are often the result of the causal factors identified. In a text of this nature, it would be impossible to identify all behavioral manifestations that place an individual at risk.

Part 4 presents information regarding one of the major results of at-risk behaviors—dropping out of the educational system. In addressing this issue, the last chapter in the text identifies both regional and national programs that have proven to be effective in working with at-risk populations.

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We would like to thank the 22 authors who contributed their expertise, knowledge, and experience in the development of this text. We would also like to thank our families who provided the freedom and encouragement to make this endeavor possible. Our thanks are also directed to Dr. W. Mark Hamilton and Elaine Pirrone of the AACD staff for their encouragement and editing skills. Thanks also to Kate Flanagan, graduate assistant at Portland State University, who eased the burden of this task.

Special acknowledgment must be given to the Center for Urban Research in Education (CURE) of Portland State University and Portland Public Schools. Without CURE's support, this book would not have been possible. A special faculty development grant to the senior author/editor, from the Office of Academic Affairs of Portland State University, facilitated a reduced graduate teaching load and the completion and publication of this book.

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Dr. Capuzzi's publications have appeared in journals such as *Counselor Education and Supervision*, *Counseling and Values*, *Humanistic Education and Development*, and the *Journal for Specialists in Group Work*. From 1980 to 1984, he served as editor of *The School Counselor*. Dr. Capuzzi has authored a number of textbook chapters and monographs on the topic of preventing adolescent suicide and is co-editor and author, with Dr. Larry Golden, of *Helping Families Help Children: Family Interventions With School Related Problems* (1986), and *Preventing Adolescent Suicide* (1988).

Dr. Capuzzi has won a number of awards for his contributions of service and expertise to professional groups. Among these are the Kitty Cole Human Rights Award of the American Association for Counseling and Development, the Leona Tyler Award of the Oregon Counseling Association, the Outstanding Service Award of the Western Region of the American Association for Counseling and Development, and the Silver Award for Editorial Excellence of the Society of National Association Publications.

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Part I

INTRODUCING THE PROBLEM

Chapter 1

DEFINING YOUTH AT RISK

Douglas R. Gross and Dave Capuzzi

The sophomore English class was in the 5th week. Janeen Adams, a 3rd-year teacher at Gabrial High School, was administering an examination covering the past week's study of grammar and composition. As she gazed at the 24 students seated in front of her, her thoughts went back to conversations she had had over the past 2 weeks with four of these students. Bob, a quiet young man, had stopped to talk with her regarding his lack of friends and feelings of being alone and isolated from his peers. He is an only child and his parents are divorced. Bob can't seem to find his place in the school, and both his attendance and his attitude seem to be affected by this. Janeen offered some suggestions but felt that Bob ought to see the school counselor. Bob did not seem to accept this idea and said that he would work something out. He was not in class today for the examination; in fact, he had not been there for the past 2 days. Janeen had given his name to the school counselor and hoped that something could be done before Bob dropped out of school or took more drastic action to solve his problems.

Judy Gorman was pregnant and had asked Ms. Adams what she should do. She did not want to have the baby but, due to pressures from home, felt that an abortion was not an option. Her boyfriend was not supportive of her and wanted to break off the relationship. She thought about running away to her sister's, but decided that that would not work because her sister had two small children to care for and Judy felt that she would be a burden. She seemed to have nowhere to turn. She had talked with her friends, the school nurse, her parents, and now with Ms. Adams. Answers that made sense to her were not forthcoming. She seemed serious about leaving home and school, and Janeen did not seem able to change her mind. Judy was in class today but Janeen worried about tomorrow.

George Borden and Craig Mellon had stopped after class last Thursday to talk to Ms. Adams regarding their friend, Pete. Pete was not in class that day and, according to his friends, he had gotten drunk the night before and was sleeping it off at home. Both George and Craig said that Pete did this quite often and it had gotten to the point that they were afraid to be with him. He got into fights and was not above breaking the law to get what he wanted. Both George and Craig admitted to drinking and some drug use; in fact, they said that most of their peers were also involved but that Pete was, in their words, "going off the deep end." They wanted to stop him but did not know how to go about it. Ms. Adams only listened—she too was at a loss as to how they could help Pete.

As the period ended, Janeen decided she would talk with Paul Bryon, the school counselor. She needed not only answers to some specific questions for the four students with whom she had talked but also information as to what was being done or what could be done to help these young people. It was her feeling that this was only the tip of the iceberg and that a large number of students in her five English classes were facing many of the problems these four presented.

The problems of these hypothetical students and the answers and information sought by the hypothetical teacher are at the very heart of the human issue currently labeled "at-risk" youth. This is not a new issue. According to Conrath (1988), "Principals and teachers have known at-risk youth for a long time. They have recently been discovered by policy makers and budget sculptors, and the discovery is progressing into implementation strategies for dropout prevention" (p. 36). Nor is this an issue surrounded by simple answers and agreed-upon definitions. The concepts that surround the student at risk are complex, filled with frustration for those who attempt to understand them, filled with despair for those who attempt to affect them, and filled with tragedy for the individuals who meet the criteria for being at risk. Few issues in American education have generated more public debate or greater activity. The results of the debate and the activity are yet to be determined. What is known at present is that a multitude of our nation's youth are at risk and that strategies must be developed to stem the growing loss of human potential. This chapter introduces the reader to concepts and issues that surround the term "at risk," identifies the population, presents at-risk data from a developmental and educational perspective, and provides the reader with an overview of the 14 chapters directed at working with youth who are at risk.

Concepts and Issues

Many problems are encountered in attempting to understand the concepts and issues that surround the term "at-risk" youth. Such problems center upon definition, cause and effect, calculating and determining the population, and the development and implementation of programs that will affect the various behaviors that place youth at risk. It is impossible to trace the exact origins of the term "at risk" as it applies to education and youth, but during the past 10 years the term has appeared frequently in educational literature, federal reports, and legislative mandates from individual states. In the September 21, 1988, issue of *Education Week*, Minga reported that three out of four states have either adopted or are preparing a definition for their student populations determined to be at risk. A review of these definitions indicates the lack of clarity and consensus about the term. One point does come through in all such definitions—the term is used to indicate individuals who are at risk of dropping out of the educational system. The characteristics of at-risk youth presented in these selected definitions contain such well-known risk factors as tardiness, poor grades, low math and reading scores, and failing one or more grades.

Factors such as these are certainly not new information for any person who has made his or her career in education. A more interesting listing of characteristics was adopted by the Montana State Board of Education in April 1988. This definition, as reported by Minga (1988), is as follows:

> . . . at-risk youths are children who are not likely to finish high school or who are apt to graduate considerably below potential. At-risk factors include chemical dependency, teenage pregnancy, poverty, disaffection with school and society, high-mobility families, emotional and physical abuse, physical and emotional disabilities, and learning disabilities that do not qualify students for special education but nevertheless impede their progress. (p. 14)

The definition speaks directly to the confusion that surrounds the issue of being at risk and somewhat indirectly addresses concerns regarding cause versus effect. From this definition it could be concluded that behaviors such as tardiness, truancy, low grades and so forth are the effects of the myriad causal factors. If programs dealing with at-risk youth attempt to deal with factors such as tardiness, truancy, and low grades, perhaps they are placing the proverbial cart before the horse. If the desired effects are to reduce tardiness and truancy and to improve grades, with the ultimate aim of reducing the dropout rate, perhaps more attention needs to be directed at identified causal issues.

The position set forth by the authors of this book is that the term "at risk" is descriptive of a set of causal/behavioral dynamics that place the individual in danger of a negative future event. With school-age persons, one of these dangers may be that of dropping out of school; with others, it may be the danger of dropping out of life. when viewed from a causal/behavioral perspective, the concept of being at risk broadens, and dropping out is only one of many possible outcomes. Others would include, but not be limited to, graduating without an education, without goals and objectives, without direction for what comes next, without an understanding of potentials and possibilities, without appreciation for self, or without a knowledge of one's place in the larger society. Limiting the perspective of being at risk to dropping out of school not only does not do justice to the severity of the problem but also places individuals at greater risk for not receiving the attention they need to change risk-oriented behavior(s).

When viewed from a causal/behavioral perspective, the concept of being at risk takes on new dimensions and places the emphasis on individual and systemic dynamics which, if not dealt with, could well lead to a wide range of destructive effects. Such a viewpoint focuses on questions such as, Why are young people at risk? and What factors place them at risk? and directs attention to a set of causal issues and resultant behaviors that often have proven to be significantly related to the many personal and educational dilemmas today's youth face. Any one of these dilemmas could result in personal and educational impairment. In combination, the results could be both personally and educationally fatal. The content of this book is directed at the causal/behavioral dynamics aspect of being at risk and presents for its readers both information and strategies to deal with these dynamics from a developmental/preventive perspective.

The Target Population

One of the basic issues confronting those wishing to work in the area of at-risk youth centers on the identification of the target population. Who are these persons identified as being at risk? Are not all young people, based upon behaviors, environment, and developmental patterns at risk? Is it possible to separate out a special population of young people who, by behavior or circumstance, are *more* at risk than others? How does the professional determine where to concentrate his or her efforts and skills? Answers to these questions are not readily available. Much of the research directed at the at-risk population centers on the negative outcomes that result from at-risk behaviors such as poor grades, absenteeism, dropping out of school, and suicide. This research paints a bleak picture and provides its readers with the devastating human toll, which is too often the end result of youth at risk.

Drawing upon studies such as those of Paulu (1987); Hahn (1987); Barber and McClellan (1987); and Kushman and Hathaway (1988), it is easy to conclude that the impact stemming from at-risk behaviors touches all aspects of our social system. Paulu, reporting on at-risk behaviors related to dropping out of school, stated:

> In the 1985–86 school year alone, the most recent for which reliable figures are available, 682,000 American teenagers dropped out of school—an average of 3,789 each day. In urban school districts from Boston to Los Angeles to Honolulu, up to half of all students entering ninth grade fail to graduate 4 years later. For most of the 682,000, dropping out will thwart dreams and frustrate expectations. (p. 1)

In addressing the public cost of leaving school prior to graduation, Paulu had the following to say:

> But the price of dropping out also extends into the public realm. Dropouts cost American taxpayers many billions in lost local, state, and federal tax revenues. Nor are all costs in dollars. Seventy-one percent of prison inmates never completed high school. Dropouts become heads of households, where the cycles of their own lives are repeated. (p. 2)

Hahn (1987), in his synthesis of a broad array of research findings and program practices in dropout services and prevention, reported:

> The U.S. General Accounting Office (GAO) reports that, in 1985, 4.3 million young people between the ages of 16 and 24 dropped out of school—13% of the age group. Of these, 3.5 million were white, 700,000 were black, and 100,000 were from other groups. Moreover, male dropouts outnumbered female dropouts: approximately 16% of males between the ages of 18 and 19 were dropouts, while only 12% of females in the same age group had dropped out. (p. 257)

Hahn does, however, caution the reader regarding the lack of consistent practices in defining and tabulating dropout statistics. This lack of consistency tends to skew the figures often reported in the press. His research indicates that dropout rates may well be declining in all but the nation's largest cities. He reported the following:

> Dropout rates for the country as a whole are not growing worse. The public has been led to believe proclamations of "record" high dropout figures. Actually, in the 1960s the proportion of dropouts in the 16- to 24-year-old age group stood at about

> 20%. Since then, the rate has declined and remained somewhere between 13% and 14%. Among black youths, the rate fell from 21% in 1974 to 15% in October 1985. (p. 257)

Regardless of the exactness and precision of the data regarding the number of young people leaving our school systems prior to graduation, the numbers are startling. The impact on our social structure, as reported by Paulu (1987), is far-reaching. Nor is the identified population limited to the stereotype of the hopeless, unmotivated, or academically limited. The problem permeates all strata of youth. Fine and Rosenberg (1983) made this point when they stated:

> Who leaves school and why are critical questions for educators and policy makers. Although the answers vary by gender, race, and social class, the prevailing image of dropouts *simplifies complex realities* (our emphasis). Dropouts are presented as hopeless, inadequate, or too poorly motivated to compete in traditional academic settings. However, empirical data demonstrate that many adolescents who leave school are academically and intellectually above-average students, keenly aware of the contradictions between their academic learning and lived experiences, critical of the meritocratic ideology promoted in their schools, and cognizant of race/class/gender discriminations both in school and in the labor force. (p. 259)

The data related to the dropout point to a population that is large, even when viewed from the most conservative of estimates. This population includes youth representative of all ethnic, racial, societal, and ability groupings. Comprehending both the numbers involved and the inclusive nature, as this applies to a broad spectrum of youth, is a first step in attempting to understand the complexity of issues about population identification. Such knowledge allows readers to begin to develop parameters within which they can start to zero in on the target population. Within this dropout population rests the core of young people *most* at risk.

Further delineation is necessary, however, if those working in this area are to achieve an effective impact on this population. Greater specificity may be gained if this population is viewed from differing perspectives. The following sections address the concept of being at risk from a developmental and educational perspective.

Youth/Adolescent Perspective

Although the developmental period most descriptive of this at-risk population is adolescence, it is not the purview of this chapter to review the vast quantity of research that has been written about this developmental period. This section is included because it provides further parameters and aids in narrowing down the target population.

Throughout the literature, terms such as *adolescents, youth, teenagers,* and *young people* are used somewhat interchangeably. Powell (1987), in a book providing guidelines for parents, said:

> The word "teenager" describes the group of young men and women who are no longer children but who are still short of adulthood. It is a generic term as are "adolescent," "youth," or "young person." While most of these individuals about whom we are concerned are thirteen to nineteen, the age boundaries are elastic, because "teenage" is a state of mind and activity. (pp. 3–4)

Newman and Newman (1986), in their text entitled *Adolescent Development*, provided further delineation:

> Adolescence is a period of life that is often mentioned as the time of transition between childhood and maturity. . . . Some people argue that adolescence is a by-product of the technological society. In this view, adolescence occurs as a result of the long periods of education and training that are required in a technological society in order to learn what is needed to perform meaningful work and to be an adequate parent. Societies create adolescence by refusing young people access to adult roles. . . . Our own view is that adolescence is a period of growth arising from both biological maturation and efforts at socialization. (pp. 2–3)

Ingersoll and Orr (1988), in an article dealing with adolescents at risk, discussed G. Stanley Hall's 1904 view of adolescence as a phase of "storm and stress" and countered that with the views of more recent writers who have taken these assumptions to task. They concluded, however, by stating:

> Still, for those who deal with adolescents in a therapeutic context, there remains a subgroup that does experience storm and stress, whose transition to adulthood is marked by turmoil and trial. Further, only a recluse could be unaware of the statistics that show an upsurge in adolescent suicide, pregnancy, and venereal disease, as well as continued patterns of drug and alcohol use and abuse, school dropouts, and delinquency. For some young people, adolescence is an extended period of struggle; for others the transition is marked by al-

> ternating periods of struggle and quiescence. During periods of stress and tumult, this latter group's ability to draw on effective adaptive coping behaviors is taxed. The resulting maladaptive behavior risks compromising physical, psychological, or social health. These young people are at risk. (p. 1)

Whatever definition or description is accepted, this developmental period is characterized by rapid physical change, striving for independence, exploration and implementation of new behaviors, strengthening peer relationships, sexual awakening and experimentation, and seeking clarity relating to self and one's place in the larger society. Add to this the pressures exerted by family, school, peers, and society to conform to or react against established standards and it is not difficult to understand the highly pressured environment of adolescents and the degree of vulnerability that exists for them. Degrees of stress would seem a logical outgrowth of this developmental period.

Adolescence seems most descriptive of a period of development characterized by such terms as *stressful*, *vulnerable*, *wandering*, *searching*, and *striving*. The emerging adolescent developmental profile taken from the research provides the reader with not only developmental issues tied to biological change such as puberty, but also personal and social issues. These incorporate areas such as the exploration and development of personal uniqueness and its relationship to other human beings, the gradual departing from parental authority and the strengthening of personal autonomy, the striving for achievement and competence, and the breaking through a characteristic form of egocentrism that David Elkind (1967) labeled the "personal fable." This fable centers on a story the adolescent tells him- or herself regarding personal uniqueness, immunity, and immortality that the adolescent believes to be true. Within this profile are found many of the common denominators that differentiate the individuals who pass through this developmental process seemingly unscathed and those who, in an attempt to meet the challenges, either by choice or circumstance, are unable to deal with the challenges effectively. Within this profile rests the youth at risk.

What is it that makes the difference? What factors or common denominators underlie this differentiation? Answers to these questions are at best speculative, but it is difficult to overlook both the choice the individuals make in their attempt to meet the challenges and the circumstances that surround them over which they have little control. Both factors play a key role in further delineating the target population that is the focus of this book.

The concept of choice related to the at-risk population is best viewed in terms of the selection of behaviors that will place individuals in danger based on the outcomes of those behaviors. It is their selected way of coping with the myriad challenges placed in their path that differentiates at-risk individuals from their peers. The following examples illustrate this choice factor:

1. The young person who chooses to drop out of school as a means of reducing both the stress and frustration generated by the educational process;
2. The young person who chooses either alcohol or drugs or both as a remedy for the malaise he or she feels;
3. The young person who chooses pregnancy as a means of escaping a negative home environment;
4. The young person who chooses gang membership as a means of increasing his or her self-identity and need for acceptance; and
5. The young person who chooses suicide as a means of escape from what is viewed as a hopeless situation.

Choices such as these that place individuals at risk may stem from the need for what seems an immediate solution, the lack of decision-making ability, the absence of significant persons to aid in providing alternative choices, or imitative coping strategies the individual has seen modeled by significant others. Regardless of the source, the individual's limited choice repertoire is a key factor in identifying those most at risk.

The concept surrounding the term *circumstance* relates to factors within the young person's environment over which he or she has little control but that play a fundamental role in separating out those individuals most at risk. The following examples illustrate the factors related to circumstance:

1. The young person who is forced to live in a disruptive, psychologically punitive family environment;
2. The young person who is the victim of either or both physical and sexual abuse;
3. The young person who, based upon family socioeconomic circumstances, is forced to leave school to support the family financially;
4. The young person who, based on family values, attitudes, and behaviors, develops dysfunctional coping strategies to deal with the challenges presented; and
5. The young person who, based on academic ability, finds either no meaning or no success in the educative process.

Both choice and circumstance are discussed at greater length in the chapters that follow. Circumstance relates to the first section of the book, which deals with causal factors, and choice is related to the chapters that deal with specific behaviors that place the person at risk.

Educational Perspective

From an educational perspective, there seems to be a good deal of consistency regarding the characteristics/behaviors of youth who fall within the parameters of the at-risk syndrome. According to Minga (1988), Grossnickle (1986), and Hahn (1987), factors such as the following serve as "red flags" for those who are at risk:

a. Tardiness;
b. Absenteeism;
c. Acting out behaviors;
d. Lack of motivation;
e. Poor grades;
f. Truancy;
g. Low math and reading scores;
h. Failing one or more grades;
i. Lack of identification with school;
j. Failure to see the relevance of education to life experiences;
k. Boredom with school;
l. Rebellious attitude toward authority;
m. Verbal and language deficiency;
n. Inability to tolerate structured activities; and
o. Being two or more graduation credits behind one's age group.

Factors such as these, viewed either individually or in combination, aid in the identification process. Young people who, on a consistent basis, demonstrate any of these behaviors or characteristics should be viewed as "prime" candidates for intervention programs dealing with those at risk. This type of identification, however, touches only the surface of the problem. The causal factors that lead to these behaviors must be addressed if intervention programs are to be effective.

Ekstrom, Goertz, Pollack, and Rock (1986) attempted to address these causal issues in their analysis of data from the U.S. Department of Education's High School and Beyond national sample of 30,000 high school sophomores and seniors. The authors looked at sophomores in 1980 and 1982 and concentrated on the differences between graduates and nongraduates. Their findings indicated that behavior problems and low grades were major determinants of dropping out. Added to this were areas such as family circumstances that included few educational supports and parents uninvolved in the ongoing process of their child's education. The authors also found that dropouts tended to have close friends whose attitudes and behaviors also indicated alienation from school.

Wehlage and Rutter (1986) argued that much of the research dealing with causal factors for dropping out of school have focused on characteristics such as race, socioeconomic status (SES), and home environment. Factors such as these are either unchangeable or at best difficult to change. They feel that research should focus on the "institutional character" of schools and what can be done within this structure to hold students. This argument is also supported by Rumberger (1987), who called for more research on how schools themselves influence students' decisions to stay or drop out.

Kushman and Hathaway (1988), in a working paper for the Portland Public Schools, addressed this issue of how schools influence the decisions of young people by discussing the work of Wehlage and Rutter (1986) and Fine (1986). In both studies the emphasis was on factors within the school environment that increased the dropout potential for the population studied. In the Wehlage and Rutter study, the authors, using discriminant analysis, selected independent variables that were descriptive of students who fell into three groups: those who had dropped out, those who stayed, and those who were college-bound. Their findings led to two sets of discriminant functions descriptive of those who dropped out. The first dealt with low SES, low student expectations, and low academic performance. The second set of factors addressed the school experience and indicated that this experience leads to disengagement, alienation, and loss of commitment to the goals of graduating and continuing with education.

Fine (1986), in her study of a comprehensive high school in upper Manhattan, concluded that the school's structural characteristics that may lead to dropping out include: (1) a school that has a disproportionate share of low-achieving students and insufficient resources to provide for this population; (2) overcrowded classrooms; (3) teachers who are predominantly White, leading to poor communication with minority students and a lack of understanding; and (4) teaching styles that are based more on control than conversation, authority than autonomy, and competition than collaboration. These findings led Fine to describe the disempowerment of both teachers and students and how this disempowerment affects the at-risk behavior of dropping out.

In addressing this problem from the students' perspective, Barber and McClellan (1987) and Paulu (1987) reported on the reasons students gave for leaving school. Although both listings included personal reasons such as family problems, pregnancy, academic problems and so forth, the *lack* of factors such as individual help, more challenging classes, more understanding, support, and help by teachers, smaller classes, more consistent discipline; and the *presence* of factors such as boredom as well as communication problems with teachers, counselors, and administrators speak directly to problems inherent in the educational structure.

The educational perspective, as this addresses at-risk youth, is discussed at greater length in the chapters that follow. It is important to note, however, that the research dealing with factors that correlate highly with dropping out of school is vast. Studies dealing with the impact the school environment has on this process and the causal relationship between this environment and the enhancement of at-risk behaviors in young people, however, is still in its beginning stages.

Overview of Text

This text, *Youth At Risk: A Resource for Counselors, Teachers, and Parents*, is based on the following assumptions: (1) Persons working with young people need information that helps them identify the individual(s) most at risk within the population; (2) Persons working with young people need to understand the causal factors that identify the individual(s) most at risk within this population; (3) Persons working with young people need to be able to identify the behaviors that place the individual(s) most at risk within this population; (4) Persons working with young people need to not only understand but also be able to use effective techniques to deal with the identified behaviors that place the individual(s) most at risk within this population; and (5) Persons working with young people need a resource that provides information related to existing programs that have proven to be effective in working with individual(s) most at risk within this population.

To meet these assumptions, the text has been divided into four parts. Part 1 contains two chapters. Chapter 1, "Defining Youth At Risk," by Gross and Capuzzi, introduces the area of at-risk youth; presents information relative to population identification, issues and concerns, and the concept of being at risk from both a developmental and educational perspective; and serves as an overview of the text.

Chapter 2, "Poor Soil Yields Damaged Fruit: Environmental Influences," by McWhirter and McWhirter, surveys some of the environmental influences that affect the lives of adolescents, stressing associative rather than causative relations. The authors present a conceptual and organizational framework for viewing the issue related to working with at-risk youth.

Part 2 of the text focuses on causal factors related to at-risk behaviors and contains five chapters. Chapter 3, "The Harmful Effects of Dysfunctional Family Dynamics," by Palmo and Palmo, presents information on the effect of family dynamics on the development of at-risk behaviors in youth, therapeutic treatment modalities for dysfunctional families, the use of referral and consultation with families of at-risk children, and the process of assessment with families of at-risk youth.

Chapter 4, "Bodily Assault: Physical and Sexual Abuse," by Rencken, presents the incidence and effects of physical and sexual abuse, the dynamics of the youthful offender, and strategies for intervention. Intervention strategies are reviewed for both immediate and delayed timeframes.

Chapter 5, " 'Who Cares What I Think?': Problems of Low Self-Esteem," by Meggert, examines low self-esteem as one of the primary causes of at-risk behavior and provides a framework and strategies to aid in creating positive levels of self-esteem.

Chapter 6, "When Life Seems Darkest: Adolescent Depression," by McWhirter and McWhirter, addresses the symptoms, causes, and treatment of adolescent depression, providing the reader treatment modalities through case illustrations.

Chapter 7, "The Society We Live In: Stress and Coping," by Terry and Milliken, provides information related to the stress response mechanism; explores the daily stressors of youth as these relate to biological, developmental, and individual relationships; and provides application and intervention techniques as well as recommendations and suggestions for program implementation.

Part 3 of the text deals with at-risk behaviors and includes six chapters, each dealing with a specific behavior that places the young person at risk. Chapter 8, "The Secret and All-Consuming Obsessions: Anorexia Nervosa and Bulimia Nervosa," by Kempley and Weber, addresses anorexia nervosa and bulimia nervosa from a female perspective, presents relevant sociocultural factors that set the stage for vulnerable adolescents to respond to both internal and external stressors by developing an eating disorder, stresses signs and symptoms that alert the helping professional, and presents theories of both causation and treatment to deal with the problem behavior.

Chapter 9, "Female, Single, and Pregnant: Adolescent Unwed Mothers," by Thompson and Sherwood, presents information regarding both current and future projections as these apply to the extent of the problem, needs of the adolescent mother, and intervention methods to work with this population. Exemplary prevention and intervention programs are presented.

Chapter 10, "No Guarantee of Immunity: AIDS and Adolescents," by Gray and House, focuses on AIDS information the helping professional working with adolescents needs. The authors stress the importance of learning the information related to AIDS and comprehending the anguish that AIDS is causing in our society, and suggest that the helping professional integrate this information into practices to deal with this population.

Chapter 11, " 'I Don't Want to Live': Suicidal Behavior," by Capuzzi and Gross, presents information regarding both current and future projections as these apply to the extent of the problem, signs and symptoms that alert the helping professional, and causation and treatment modalities that are descriptive of the population and the intervention strategies utilized.

Chapter 12, "Tough Enough: Gang Membership," by Boozer, examines the youth gang phenomenon, setting the modern youth gang within the context of history and literature. The author presents information dealing with profiles of youth especially at risk of gang involvement and includes a case study that illustrates common manifestations of risk factor patterns. Ethnicity as a factor in the organizational structure of gangs is also presented. The chapter concludes with strategies found to be effective in schools that have experienced youth gang violence, and a call for a restructuring of our educational institutions in order to eliminate conditions that contribute to the emergence and growth of youth gangs.

Chapter 13, " 'Why Say No?': Substance Abuse Among Teenagers," by Robinson, examines adolescent substance abuse from a variety of perspectives—psychosocial, historical/legal, and psychophysiological. The role of schools, parents, and treatment programs is addressed.

Part 4 deals with the school dropout and school and community programs that have proven to be effective in working with at-risk populations. Chapter 14, "Understanding and Preventing School Dropout," by Kushman and Kinney, discusses the complexity of the dropout problem, and presents information that addresses the dropout issue from the perspective of the student, the family, the school, and the community. Intervention strategies are discussed that focus on both the individual and the larger system in which the individual functions.

Chapter 15, "The Solution Lies in Programs That Work," by Hathaway, Sheldon, and McNamara, contains information related to regional and national programs directed at helping at-risk youth. Programs were selected for inclusion in this chapter based on the positive effects they have demonstrated with the at-risk population.

Conclusion

For those working with at-risk youth, the challenges are many, the frustrations are great, and the population increases daily. There are no easy answers or solutions to reduce the challenges or elmininate the frustrations. The chapters included in this book highlight various aspects of not only at-risk behaviors but also skills and techniques that can be used to work with this population. As the information in chapter 1 indicates, the population identified as being at risk is not new to those who have worked in the area of education. What is new is the economic, social, and cultural impact this population has had and will continue to have on the continued growth of this country. Steps have to be taken to stem this growing dilemma.

It is the hope of the authors of this book that the information, case examples, intervention techniques, and program resources presented will provide direction and guidance in helping this growing population. It is you, the helping professional, who must take the information, techniques, and resources and apply them effectively. In the words of Hahn (1987, p. 263), "This is a large order, but this is a very large problem. And we know enough to begin."

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Chapter 2

POOR SOIL YIELDS DAMAGED FRUIT: ENVIRONMENTAL INFLUENCES

J. Jeffries McWhirter and Ellen Hawley McWhirter

Introduction

Today's youth face the challenge of growing into mature, responsible, and healthy adults amidst a storm of societal change. Advances in technology are occurring more rapidly than ever before in history, resulting in highly specialized systems of communication, transportation, and warfare—this builds additional complexity into already complex lives. The increasing mobility of the nuclear family, the disappearance of the small farm, and the closing of industries in the East and rapid development in the South and the Southwest, all underscored by a pervasive awareness of the nuclear capabilities of several world powers, make our society one in which nothing seems certain. For adolescents, already engaged in the tenuous process of moving from child to adult, these societal characteristics are added burdens that affect their development in a variety of ways. World and national instability modifies and influences the changes, events, and characteristics of local communities. This, too, affects adolescents and their families.

The purpose of this chapter is to survey some of the environmental influences that affect the lives of adolescents. Because of the inherent difficulties in experimental manipulation of the environment, much of the research presented in this chapter reflects associative rather than causative relationships. Nevertheless, these associations provide valuable information with significant implications for educational programming and for psychological and counseling interventions.

Before turning to the literature, a conceptual and organizational framework for viewing the issues related to working with at-risk youth is presented. Through the use of a metaphor, this framework helps to integrate the various topics covered in this volume. It also allows us to emphasize certain aspects of at-risk youth not considered elsewhere.

The Metaphor of the Tree

One way to view the factors related to youth at risk is to use the analogy of a tree. Consider the soil that this tree is embedded in to be the environment into which the individual is born. The environment consists of socioeconomic status (SES), cultural factors, and the political and economic climate of the times. It also includes the changes currently under way in our modern world—urbanization, the influence of technology, the feminization of poverty, and so forth. These variables interact in a complex and as yet difficult-to-quantify manner to influence the personal development of the growing child.

The roots of the tree can be viewed as the youth's individual characteristics: strengths and weaknesses, likes and dislikes, talents and disabilities both learned and inherent. Springing from the roots, the trunk of the tree is intimately linked to this multifaceted network that serves as an anchor and source of life. School and family are the primary societal institutions that mediate the development of youth and provide structures with which to assimilate experience. Throughout this text, several authors present research, treatment interventions, and programs that link individual characteristics to family and school variables and also relate individual, family, and school dysfunction to specific adolescent problems.

The branches of the tree represent adolescents' contact with and adaptation to society. Some branches are healthy, capable of bearing good fruit; others, increasingly so in modern society, are broken, defective, and deficient. They produce at-risk youth and might be said to represent specific at-risk categories: low self-esteem and substance abuse, teen pregnancy and AIDS, depression and suicide. The fruit of our tree, of course, represents individual and specific youngsters: some whole and wholesome; others bruised and damaged; still others literally dropping from the tree. Although healthy branches sometimes produce damaged fruit and broken branches sometimes produce solid fruit, the fact remains that certain characteristics increase at-risk possibilities. Eating disorders (chapter 8), pregnancy (chapter 9), suicide (chapter 11), school dropout (chapter 14), gang membership (chapter 12) and depression (chapter 6) are among the at-risk categories that yield the fruit of troubled youth.

A wide range of interventions are proposed and evaluated within the above chapters. These interventions affect the youth in different areas. Thorough eradication of the problems of youth—an ideal for which we must strive without taking leave of reality—requires that we address the full spectrum of weaknesses and deficiencies within the system itself. Problems related to the soil, roots, trunk, branches, and fruit of the tree must all be considered in a comprehensive attempt to respond to the problem. For example, comprehensive intervention models designed to prevent teenage pregnancy must consider the concrete environmental reality of the target teenagers, school and family structures and influences, individual characteristics, and the youths' manner of negotiating with their environment. A just and humane society must provide effective interventions, resources, and strategies to help troubled youth—the fruit of the at-risk situation. We simply cannot discard them to the rubbish heap: Discarded fruit become the seedlings for damaged trees of the future. Nevertheless, unless we expand our methods and our focus of helping, unless we address the *causes* of our problems, we are doomed to failure.

There is an old story that is appropriate here. A woman was standing by a river when she saw a swimmer struggling to stay afloat. She jumped in and pulled him to the bank. A bit later, another swimmer floated by in similar trouble. Again, the woman dove in and saved him. As the afternoon progressed, this happened many more times. Finally, after the woman had pulled ashore her 12th victim, she wiped her brow with a sigh and began striding purposefully upstream. An observer called to her, "Where are you going? If you leave, who will be here to save all these people?" The woman replied steadily, "I'm going upstream to stop the son of a bitch who keeps throwing these people into the water!"

Much of this book focuses on "upstream helping." We applaud early prevention efforts because they seem to minimize at-risk youth. However, we would go even further upstream to deal with the environment. Consequently, the remainder of this chapter is dedicated to an exploration of the soil: the environmental elements that have been linked with problems in adolescence. Implications for counselors are provided in a final, separate section.

The Soil

Ecological psychology views the developing child as part of an interactive and interdependent system. There is no longer a debate on whether the surrounding environment has an impact on the development of the child (Wachs, 1986). Developmental psychology has not only found ample evidence to support this statement (Hunt, 1961; Wachs & Gruen, 1982), but also specific aspects of the environment have been linked with development (Yarrow, Rubenstein, & Pedersen, 1975; Bronfenbrenner, 1979; Garbarino & Sherman, 1980). The major environmental areas to be discussed in detail are those of socioeconomic status, economic and political trends, and community variables. These seem most critical in relation to at-risk youth.

Socioeconomic Status

Perhaps one of the most commonly noted variables related to the human environment is socioeconomic status. In the social sciences, attention is often focused on the lower end of the socioeconomic spectrum and on understanding the ramifications of poverty. Understanding the dynamics of poverty among children, Cassetty (1982) wrote, ". . . is absolutely critical to devising a comprehensive strategy for dealing with virtually every other major social problem we face as a nation today" (p. 2). Although the United States is one of the richest nations in the world, there is still a significant proportion of the population living below the poverty level. According to Kimmich (1985), in 1981 over 20% of all children in the United States were living in poverty; among Black children this figure was 47%. In 1982, female-headed households made up 19% of all families, nearly twice the number of female-headed households in 1970. Among Black families, the number of female-headed households rose from 30% in 1970 to 46% in 1982. Female-headed families earned 34% of the income of husband-wife families in 1981—actually an 11% decrease in real terms from their median income in 1970 (Kimmich).

Ethnic minorities are disproportionately represented in the lower income bracket. In 1987, 6.0% of all White households were earning less than $5,000 per year, compared to 11.0% of Hispanic and 18.7% of Black households (U.S. Department of Commerce, 1988). As of 1986, 8.6% of all White families lived below the poverty level, compared to 28.0% of Black families and 24.7% of Hispanic families (U.S. Department of Commerce).

In his description of low SES, multiproblem families in the slums and barrios of America's large cities, Minuchin (1967) referred to these families as "anonymous" despite their frequent contact with societal institutions. He wrote:

> Their joblessness, lack of productivity, antisocial behavior, and chronic dependency on various social institutions repre-

> sent not only an enormous financial drain on the resources of the community at large, but also a threat to the feelings of well-being and complacency of the middle classes and the more stable elements of the working class that surround them. (p. 6)

Based upon his extensive work with such families, Minuchin described social interaction problems that include deficits in vocabulary and the basic rules of communication, little or no expectation that anyone will hear or be affected by what they say, little or no expectation of reward for appropriate behaviors, and inconsistent, ever-changing rules of discipline. These deficits, combined with other characteristics of multi-problem families, create additional stresses and strains for the impoverished family.

Children from impoverished families are at an increased risk of health problems. They are more likely than middle-SES children to have experienced low birthweight, neonatal damage, malnutrition, and untreated childhood illnesses, and to have had problems in hearing and vision that were unidentified and uncorrected (Hamburg, 1987). In addition, Hamburg reported that low-SES children in general grow up in environments with high degrees of continuous stress; environments characterized by ". . . .disorganized, impoverished neighborhoods and circumstances, with socially isolated, very young mothers, without fathers, and with minimal support from other family members or friends" (p. 7). According to Ryan (1972), the consequences of poverty include insufficient access to goods and services needed for family participation in society, individual participation in the labor market, and preparation of youth for future participation in the labor market. Low socioeconomic status coupled with minority status is a strong predictor of dropout (Wehlage, Rutter, & Turnbaugh, 1987). Poverty is the single greatest predictor of adolescent pregnancy (Ennis, 1987). In addition, various studies have linked SES with problems of mental and physical health.

SES and self-esteem. Although it has not been conclusively established that there is an association between social class and self-esteem, several researchers have found that negative self-esteem is influenced by being a member of the lower SES (Ryan, 1972; Ausubel & Ausubel, 1963; Battle & Rotter, 1972; Healey, 1974; Hawk, 1967). On measures of self-esteem, autonomous and prosocial functioning, competence, and imaginative capacity, children from low-income backgrounds tend to perform poorly or rate low in terms of the norms of the core culture.

SES and child abuse and neglect. In their review of the literature on child abuse, Daley and Piliavin (1982) examined the socioeconomic variables related to incidence of child abuse. Low income and child abuse have been related in a wide variety of studies (Gil, 1970; Pelton, 1978; Young, 1964; and Shapiro, 1979). Some research indicates that poverty is a causal factor in creating conditions of social and economic stress in which abuse is likely to occur (Pelton, 1978; Gil, 1970). In a study by Gil (1970), 55.5% of the fathers in abusive families and 65% of the mothers had less than a high school education. Also, the unemployment rate for fathers was three times higher than the national norm. Shapiro (1979) found less than a high school education in 55% of the fathers and 63% of the mothers and also found a relationship between unemployment and child abuse. Young (1964) reported an association between child abuse and both low educational attainment and unemployment.

Olsen and Holmes (1986) completed a national study on the demographic characteristics of 192,000 youth who had been reported to be abused or maltreated. Law enforcement agencies, schools, Child Protective Services, and other social service agencies were the sources of the reports of abuse and maltreatment. Findings revealed that among children aged 12 years and under, nearly 50% of their families had incomes of $7,000 or less. Family income was between $7,000 and $14,000 for 40% of their families and $15,000 or more for the remaining 11%. In contrast, among the 12- to 14-year-old group, the highest percentage of maltreated youth were from families with incomes of $7,000 to $14,999. Percentages of youth from families in the lower and upper income categories were 29.3% and 25.6% respectively. Among both age groups, the lowest percentage of reported maltreatment occurred among families in the highest income bracket. Findings revealed that there was a greater willingness to report and substantiate allegations involving younger children, families of lower socioeconomic status, and non-White families. Perhaps these findings reflect a general belief that abuse is more prevalent among those groups; it may also be that fear of lawsuit or retaliation is greater when White or middle-to-upper income families are involved. In any case, these findings reflect an association between reported abuse and SES that warrants further attention.

Gaudin and Polansky (1986) suggested that neglectful mothers in predominantly lower SES neighborhoods may be more isolated than their counterparts in middle-class neighborhoods. Because a poorly developed social network has been associated with poor quality child care (Garbarino & Sherman, 1980), children of neglectful families may be more at risk if they are from low SES families than children of middle-class families.

SES and parent-child relations. In a review of the literature on the link between parent-child relations and economic deprivation, Siegal (1984) extended the trickle-down model of economics to the family unit.

More specifically, Siegal examined how economic deprivation affects the children's image of their parents and how this in turn may affect children's behavior toward adults. In addition, Siegal looked at the relationship between psychological well-being, child rearing, and economic deprivation. He concluded that children are generally not aware of or sympathetic to the difficulties associated with economic strain (Furth, Baur, & Smith, 1976; Baldus & Tribe, 1978; Berti, Bombi, & Lis, 1982; Jahoda, 1979; Siegal, 1981). Adolescents are more likely to attribute unemployment to internal rather than uncontrollable external forces (Gurney, 1981; Ho & Smithson, 1981). Thus, economic deprivation negatively affects the children's perceptions of their parents, which may in turn lead to problem behavior in boys (Hirschi, 1969) such as juvenile delinquency (McGarvey, Gabrielli, Bentler, & Mednick, 1981).

SES and stress. Members of the lower SES class have less money and education than members of the middle or upper classes. They are certain to have economic stresses in trying to make ends meet. For many, unemployment preceded their low socioeconomic status. Economic stress and unemployment have been associated with mental illness, depression, and suicide (Dooley & Catalano, 1980; Sheperd, 1981). Stressful life events such as low or unpredictable income are related to poor psychological well-being in young mothers (Belle, 1980). Conditions of economic stress also have been associated with less favorable perceptions between mothers and children, fewer supportive behaviors from mother to child, and more negative behavior at home on the part of the child (Zelkowitz, Saunders, Longfellow, & Belle, 1979).

As Siegal is prompt to point out, the studies he reviewed provide evidence for association, not causation. Controlled experimental investigation of the effects of economic deprivation would be difficult if not impossible to arrange without abandoning ethical principles. Nevertheless, the vast weight of the findings hints that conditions of poverty add an additional, complex set of problems and difficulties to the lives of adolescents and their families. Issues related to working with a low-SES population are addressed later in this chapter.

Economic and Political Trends

The 1980s have seen significant decreases in the federal funding of programs designed for children. Such funding cuts warrant the attention of those working with adolescents. In a study of federal budget cuts and their effects on children in the United States (Kimmich, 1985), 16 of the major programs for children were examined. Eight social service programs showed an overall decrease in real dollar funding of 14.4%

in the years 1981–1984, detailed in Table 1. Additional programs that experienced cuts in funding and the corresponding percentages of the cuts include the preventive health and health services block grant (35.3%); mental health (25.7%); school breakfast and lunch programs (40.7%); CETA youth training (53.1%); and AFDC (19.3%).

State and local responses to the federal budget cuts have varied, but several general trends can be observed. Programs focusing on crisis needs have been given priority over preventive programs. In the health care area, specific, child-oriented programs such as those focusing on sudden infant death syndrome, rat control, and lead-based paint poisoning have lost funding in order to maintain more broadly based programs providing basic medical coverage. Shifts in medicaid funding affect families in that options for health care have decreased whereas payments have increased; education and employment services, particularly those aimed at disadvantaged youth, have suffered even more funding and program cuts (Kimmich, 1985). Returning to our metaphor, if any funding at all is provided, it is to patch up bruised fruit.

Kimmich (1985) warned that the current shift away from social and educational services seriously limits the effectiveness of children's services in the future. She stated:

> Social services have long been the most income-dependent services, often designed to alleviate family stresses arising from unemployment, single parenthood, and other factors leading to low income. As government support for such programs

TABLE 1

Funding for Social Service Programs*

Program	*Percent Change*
Social services block grant, Title XX	−13.5
Child welfare, Title IV(B)	−16.7
Foster care and adoption assistance; Title IV(E)	19.0
Child abuse and neglect	−12.3
Head Start	9.7
Work incentive program child care	−100.0
Juvenile justice and delinquency prevention and runaway youth programs	−19.8
Community services block grant	−48.0

From *America's Children: Who Cares? Growing Need and Declining Assistance in the Reagan Era* (Table A, p. 16) by M.H. Kimmich. © 1985, Washington, DC: The Urban Institute Press. Reprinted by permission.

*Table title by chapter authors.

> decreases without concomitant increases in funding from the private sector, it is the poor and needy children who will suffer the most. (p. 93)

It should be of great concern to counselors, educators, and parents to know that these funding cuts take place despite evidence that the eventual cost to society will be greater than the cost of the programs. The cost of maintaining adolescents in state hospitals, juvenile detention centers and homes, alcohol and drug treatment programs, to say nothing of legal expenses, is phenomenal. If the long-term goal of counselors is indeed to "put ourselves out of business," then funding decisions must be made in consideration of future costs. We will return to this issue in the final section of the chapter.

Community

Garbarino (1982) described "community" as a geographic locale in which control, participation, socialization, support, production, distribution, and consumption functions are fulfilled through a variety of social and economic systems. The specific characteristics of a community are influenced by its history, its power structure, and its citizens, as well as outside events and trends. According to Garbarino, environmental support for families within a community is determined by the nature of local government practices, parents' workplace, the relationship between home and school, and the community's response to the need for daycare services. Each of these avenues of support will be examined in greater detail, along with network support, another important variable.

Local government. Local government, in its policies and actions regarding residential area regulations, pollution control, and renovation efforts, can undermine or support the family. Neighborhood improvement efforts can be facilitated or hindered by local government. Industrial pollution can cause deterioration of neighborhoods and radically affect the nature and pleasantness of a neighborhood, reduce property value, and discourage new growth. Modification of zoning regulations can allow businesses to enter an area, which can change the composition and character of a neighborhood. The responsiveness of the local government to community input via grass-roots organizations is an important feature of a community. Openness, encouragement, and support of grass-roots efforts can enhance the willingness of citizens to take responsibility for their neighborhoods, encourage greater participation in local elections, and facilitate greater contribution to and involvement in the community.

Garbarino, Gaboury, Long, Grandjean, and Asp (1982) proposed that government play an active role in encouraging the private sector and nongovernmental agencies, such as neighborhood associations, churches, and nonprofit organizations, to combine their resources in support of the family. Tax incentives, changes in work hours, and funding for prevention programs are among the possibilities that would provide increased support for families within the community.

Counselors can assist in this process in several ways. Keeping up to date on community affairs, promoting networking among social service agencies, developing or maintaining lines of communication between policymakers and the human services sector, and encouraging dissemination of information regarding community needs and available programs to government officials and the community at large are but a few ways that counselors can facilitate changes in the environment that positively affect families and therefore adolescents.

Workplace. The workplace of the parents can influence family life via the existence of mass transit systems; openings, shutdowns, and layoffs in business or industry; wages; and unemployment levels. Work-hour flexibility, advancement opportunity, and job benefits are also variables that directly affect the worker and family (Cotterell, 1986).

Gordon (1985) provided a dramatic example of the effects of the workplace on families within a South African community. Gordon described what she considers to be a case of communitywide "learned helplessness" in which a timber-producing company had significant control over the workers and their lives. Researchers assessed the workers living on the company plantation as the most passive of all the company's employees. Numerous regulations restricted the activities of this community, with fear of dismissal a common theme. There were few social or recreational activities, nor was there any organized structure for decision making or negotiation. Workers were uninvolved with the community and did not perceive themselves as able to make any changes in their situation. Although the community is in South Africa, this description is similar to the situation of non-union factory workers, unskilled laborers, farm workers, and others in this country whose lack of education and organization frequently leave them unaware of their rights and at the mercy of their employers.

A community development program was undertaken to provide training in leadership, conducting meetings, and organizational skills for the plantation workers. A local resident was appointed to serve as a liaison between workers and management, and hearings were organized for unfairly dismissed employees. After 1 year, workers were demonstrating significant levels of autonomy by organizing regular recreational events, holding elections within community committees, and organizing cooperative ventures in plowing and herding.

By introducing mechanisms and training for implementing even small amounts of control, significant and positive changes occurred among the workers and their families. The workplace was still a dominating force in their lives, but their response to the system had changed. These results have important implications for counselors working with adolescents and families. They lend promise to the second option of the age-old dilemma—do we assist clients to accept their life situations and adapt to their hardships, or do we facilitate their challenge of the status quo? The question is neither as simple nor as black-and-white as it seems here, but in some form or another it lies at the heart of every therapeutic intervention.

Schools. Size of schools, the areas they serve, assistance available to low-income families, transportation, and the existence of bilingual educational opportunities affect children and their families. Educational policies and reform have direct and significant impact upon children, adolescents, and their families. Aubrey (1988) reported that although the need for educational reform in the schools is agreed upon, and even when "excellence" is the goal of such reform, definitions of excellence are numerous and frequently incompatible.

One frequently used definition of excellence is higher standardized test scores, which could be achieved through decreasing electives and increasing the required number of college preparation courses. Heavier emphasis on the "basics" would presumably increase learning in the areas addressed by standardized testing. It may also lead to an increased dropout rate, resulting in a smaller pool of test takers who presumably do better on standardized tests. An alternative, and according to Aubrey "all too infrequently" used, measure of excellence would include indices such as declining dropout rates, declining violence, lowered occurrence of vandalism, and greater involvement of students in the local community. These measures of excellence would involve the implementation of different strategies. Consider the impact of each "type" of excellence on one subgroup of children: ethnic minorities.

In a review of the literature related to the status of ethnic minorities in primary and secondary education, Moore (1988) suggested that factors such as low expectations on the part of teachers and the students themselves contribute to lower achievement of minority students. Ethnic minority children also frequently enter school with attitudes and information processing skills that conflict with instructional modes and the teachers' style. Discouragement and dropout are common among these children and adolescents; confronting them with an increase in college preparation requirements may only add to despair and may not result in *any* increases in their particular test scores. Moore suggested that achievement can be enhanced among these children through a variety of means including early vocational counseling, educating teachers about appropriate and inappropriate applications of standardized test score data, and facilitating understanding of cultural differences between teachers and pupils. These interventions may help to make the educational process more appropriate, interesting, and beneficial for ethnic minority students and produce results such as decreases in dropout and vandalism; standardized test scores, however, may not improve in a statistically significant way.

Test score increases are the far more common interpretation of "excellence." Counselors, parents, and educators are daily witnesses to the effects of school policy upon children and adolescents. We are in a unique position to witness the cost of "raising test scores" and other educational changes. If scores increase and dropout doubles, do we dare call our efforts successful? Some definitions of excellence may lead to very negative outcomes for at-risk groups of adolescents. Hodgkinson (1985) highlighted the importance of this issue. Results of his study indicate that children entering our school systems in the future will increasingly be children who: are from single parent homes; were born to teenage mothers; were born prematurely; are living as latchkey children; and are children living in blended families. He predicted that dropout will remain high, especially among Black and Hispanic youth, fewer minority youth will enter high school, and a smaller percentage of children will have participated in Head Start and other preschool programs. Hodgkinson also predicted that by the year 2000, school children will be poorer and more ethnically and linguistically diverse than ever before. Issues of school reform and educational progress demand our concern, attention, and response.

Day care. The makeup of a community and its political structure may influence day-care opportunities for parents. Where parents are organized or have a political voice, day care may be given a high priority. Local government can encourage businesses, organizations, and industries to provide day care through incentive programs, and consistent regulation and inspection of such facilities can ensure program quality. Funding may be regularly allocated to day-care programs or directed away from day care in favor of other services and organizations. A community's commitment to the family may be measured in part by its efforts to provide day care.

Network support. One final aspect of the community to be addressed here is network support. Network support refers to the informal set of relationships that an individual has with neighbors, friends, and coworkers that provides emotional, informational, and instrumental assistance or resources. In a review of the literature on social support, Leavy

(1983) reported that across all studies one finding is consistent: the absence of such support is associated with increased psychological distress. Neighborhood characteristics, such as stability (Garbarino, 1982), have definite effects upon the availability of social support networks.

As mentioned earlier, research indicates that quality of child rearing is affected by the adequacy of the mother's social network (Garbarino & Sherman, 1980). Neglectful families have poor quality child rearing. In a study of the social isolation of neglectful mothers, Polansky, Chalmers, Buttenweiser, and Williams (1981) found that neglectful mothers not only lacked social and relationship skills, but were also isolated and rejected by others. Gaudin and Polansky (1986) showed a difference between responses to non-neglecting and neglecting families, with subjects evidencing clear distancing from neglectful families.

The quality of child rearing also has been linked to social support. Cotterell (1986) found that the mother's network support exerted a powerful influence on her child-rearing processes. Cognitive stimulation, maternal warmth, mother-child play, and teaching were significantly related to the mother's support; mothers with greater support engaged in these behaviors more frequently than mothers with less support.

Cohesiveness has been described as the extent to which individuals view their neighborhood as supportive, friendly, and a potential source of help (Cohen, Struening, Muhlin, Genevie, Kaplan, & Peck, 1982). Individuals who view their neighborhood as cohesive apparently experience support, friendship, and helpfulness via a social support network. In a study by Cohen et al., neighborhood cohesion was directly predictive of two measures of well-being. Results were consistent across ethnic groups and income levels. Implications are that having a support network contributes to a general feeling of well-being.

The emphasis that network therapy places upon social networks provides additional testimony to the importance of social support (Schoenfeld, Halevy-Martini, Hemley-Van der Velden, & Ruhf, 1985). Network therapy involves the utilization of the client's family, friends, neighbors, co-workers, and significant others to provide emotional support and physical assistance to clients and their families, as well as to promote mutual sharing of responsibilities. Although it has developed slowly (Speck & Attneave, 1973), network therapy has received increasing attention and has been the focus of several studies (Garrison, 1974; Rueveni, 1979; Beels, 1981; Trimble, 1981; and Schoenfeld et al., 1985). In a study by Schoenfeld et al. (1985), situationally, demographically, and diagnostically similar clients were compared to clients who received network therapy. Posttreatment utilization of mental health services showed a 17% decrease in usage by those clients who had been recommended for network therapy but had not received it, compared to a 76% decrease for treatment recipients. Follow-up investigation by the researchers revealed that 1 year later all subjects but one were maintaining gains made in therapy.

Network support is a variable affected in part by the individual's ability to develop and utilize available resources; the quality and accessibility of supports is a feature of the surrounding environment. Counselors regularly assess the support networks of their clients in the therapeutic process. Education about and application of relationship and communication skills are often a part of this process, particularly with adolescents. Counselors may be in a position to go one step further—to make change in the client's environment so as to increase the amount of support available. This can evolve most naturally within the structure of the school setting. Meeting with parents and investigating the work environment may open possibilities for increased support outside of school.

Summary

The preceding sections were designed to highlight some of the features of the environment that affect adolescents. Significant features of the environment include socioeconomic status, national economic trends, and community variables. These areas are by no means exhaustive of the channels by which the environment influences development; nor is the information presented intended to provide a complete review of the literature. Nevertheless, we consider these areas to be among the most critical of those affecting adolescents. Much of the work in this area has been carried out by researchers in sociology, social work, and human development. Understanding environmental influences must therefore be multidisciplinary in order to take advantage of existing knowledge.

Perhaps the most far-reaching of these influences is socioeconomic status—particularly for those at the lower end of the spectrum. The influence of poverty extends beyond nutritional deprivation and other physical stressors into the quality and amount of education received, potential work environments, and political voice. Funding cuts in recent years have resulted in a decrease in resources available to all children but in particular the children of low-income families in the areas of health, nutrition, day care, and job training. What can counselors and educators do to address the effects of the environment upon adolescents? The following section provides suggestions and recommendations for an active approach to the problem.

Implications

It is foolish to think that major changes in our society are in the offing, or that counselors, teachers, and parents can single-handedly carry them out. Nevertheless, they can make a significant contribution to the change process in three primary ways. The first is through developing and utilizing techniques for helping individuals to confront their environments in an active way rather than promoting a passive posture toward their environmental circumstances. When facilitating the growth of awareness and skills for addressing environmental problems, counselors must be careful not to convey the message that passivity has been the cause of these problems. Caution must be exercized in utilizing this approach so that it does not take on characteristics of "blaming the victim."

One promising avenue for facilitating self-awareness and skills development is through group work. Group work can enable individuals to regain a sense of community and belongingness, while at the same time inspiring confidence and renewed hope (McWhirter, McWhirter, & McWhirter, 1988). Sue and Zane (1980) suggested that under certain circumstances, lack of personal autonomy can increase alienation, diminish the sense of community, and lead to uninvolvement in community systems and organizations. It may well be that families who are living in poverty or who are experiencing other adverse environmental conditions are unable to break free of these conditions for reasons including a perceived lack of control over their situation.

Morrow and Hawxhurst (1988) discussed a group-process model that has evolved out of the social change movement. The processes highlighted can be easily applied to group work with impoverished individuals, parents wanting more voice in the school district, workers feeling controlled and alienated by their workplace, neighborhood residents concerned about pollution, zoning, or crime, and many other groups. Among the important processes presented (Morrow & Hawxhurst, 1988; Hawxhurst & Morrow, 1984) are: empowerment (the process of recognizing personal power in oneself and others); responsibility (fostering the sense that members are responsible for facilitating one another's growth as well as their own); communication (especially recognizing that members with more societal privilege and power must not be favored over those with less power and experience); and meeting and group facilitation (teaching the skills of organizing and running meetings to *all* group members). Utilizing these and other processes in group work, in combination with educational activities, can effectively enhance awareness of the influence of the environment, encourage recognition that change is possible, and facilitate the development of skills and resources for creating change.

Turning back to the example of the plantation workers in South Africa (Gordon, 1985), it is clear that group work was effective in enhancing their personal development and political voice. The workers began to take a more active approach to coping with and changing their living situation. It has been through the widespread organization of groups that institutional changes have been made in our society, such as laws regarding civil rights and reform in care for the institutionalized. Group work can enhance a sense of power and capacity among individuals who traditionally have no power.

But counselors can't stop there. There are limitations to the systemic changes that can be made at the grass-roots level. A second way for counselors to be involved in the process of confronting the environment is to seek change at the level of those who have the power to legislate, to fund, and to affect the structure of the environment. Schorr (1988) contended that counselors have both the knowledge and the resources to address the needs of the poor and break the cycle of poverty. She views one of the major obstacles to the development of such programs as the lack of current research information on the part of administrators, academics, practitioners, and public policy analysts. Comer (1987) suggested with respect to schools:

> Economic and social risk-producing factors in the larger society cannot be greatly modified by school people. But educational policy and practice at every level of government, preservice training, and school district and building can be modified to improve the learning of students at risk. (p. 14)

As previously stated, counselors, for better or worse, have insight into the most intimate difficulties and concerns of members of our society. They are privileged witnesses to the impact that society has on individuals and groups. Counselors can silently curse the ills of society or make their observations, research findings, and suggestions known. Community education at a local and national level is a role for which counselors are well qualified. And just as a grass-roots neighborhood committee has more voice and effectiveness than a handful of individuals, counselors organized for the purpose of addressing issues and making recommendations will be more effective than isolated individuals offering suggestions.

Namir and Weinstein (1982) suggested that one hindrance to the development of adequate services for youth is the fact that so many of the solutions require fundamental sociopolitical changes. The effects of inadequate nutrition and housing, the lack of birth-control information, poverty, and discrimination cannot be prevented with crisis-oriented programs. Ultimately, prevention means changing the environment that fosters such problems. The reality is that prevention efforts must involve critical analysis of the structure of society and reflect the results of such analyses in programming, planning, and action.

Perhaps it is time to add a new dimension to the traditional counselor role. Counselors have always been advocates of individual growth and development. With growing recognition of the role that environment plays in human development, social activism is the natural arena into which counselors must move if they are to remain faithful to that advocacy. As social activists, counselors can promote awareness of the damaging effects of poverty, undernourishment, discrimination, overcrowding, and poor housing. Counselors can urge the adoption of mental health programs within schools and communities that address specific environmental circumstances, inadequacies, and limitations. Counselors can make their views known to local and national leaders through letters and votes, seminars, and publications. Counselors can be more aware of how local politics are effecting changes in mental health policy in communities.

Hurvitz (1977) regarded comprehensive societal change as a necessary condition for mental health, viewing capitalism as a system that denies physical and psychological security for most Americans. In his description of "radical therapy," Hurvitz listed a broad scope of activities oriented toward human rights, issues of labor and peace, and the development of alternate therapies and facilities. He wrote, "These activities are associated with the radical therapist's vision of and work for a non-exploitative society that fosters humanist and life-affirming relationships between people" (p. 69). Through various forms of social activism, ranging from letter writing, to professional publication, to public demonstrations, counselors can work as powerful advocates for the people they serve. The effectiveness of what counselors do in schools and agencies will be magnified by their efforts beyond closed doors and in the public eye.

A third means by which counselors can be effective in addressing the effects of the environment on adolescent development is through utilizing and promoting an economic framework for program analysis. Unfortunately, many programming decisions are based on monetary rather than human costs, short-term rather than long-term costs, and common assumptions rather than research findings. As a result, money is directed into crisis intervention rather than prevention, with a much greater cost to society. Mayer and Butterworth (1979) provided an example of the economic benefits of prevention. Vandalism in the Los Angeles public schools was costing more than $5 million each year, and over 400 personnel were involved in security and in vandalism repair. A prevention program was implemented that included participation by teachers, students, and parents; the results were considerable monetary savings as well as the noneconomic benefit of greater satisfaction among students, parents, and school personnel. It is programs such as this one that are being eliminated in favor of crisis intervention.

Beker, Eisikovits, and Guttmann (1987) presented an economic model for program evaluation using the case of farm-family adolescents. They proposed that the cost-effectiveness of intervention programs be assessed with consideration of the following factors: the economic value of adolescents; their noneconomic value; the economic cost of adolescents; and their noneconomic cost. Economic value pertains to the direct work contribution of the adolescent to the family household, both within the home and through outside employment, and also the assurance adolescents can provide that they can assist financially when needed. Noneconomic values are associated with the psychological satisfaction parents derive from their children. This satisfaction can be attributed to companionship provided by their children, emotional security, a sense of family continuity and competence, stimulation, the opportunity to guide others' lives and make sacrifices for them, and many other positive elements of family life. Economic costs of adolescents include direct maintenance expenses and the indirect costs associated with opportunities the parents miss. Noneconomic costs are psychological and emotional; they include the anxieties, concerns, frustrations, and sorrows associated with limitations on freedom, disruptions of the household, misbehaviors and problems, illnesses and economic insecurities, and the overall physical strain of having children.

Using this model, the cost-effectiveness of programs is determined by assessing economic costs. Given the optimal economic value, in dollar terms, of adolescents in the target area, subtract the dollar value of troubled youth (whose productivity is presumed to decrease); add to this figure the average net dollar cost of time lost and lowered efficiency within the family (per troubled youth) per year; and finally, add the average net dollar cost (per troubled youth) of the public and subsidized services required for the troubled youth. The resulting figure, multiplied by the actual number of adolescents in the target area, yields a quantitative measure of the net cost of troubled youth. This cost, projected over a number of years, can be compared with the cost of specific prevention programs.

Of course the greatest difficulty with this model is arriving at dollar estimates for youthful productivity, time lost, and so forth. Research focusing on the development of accurate and valid measures of economic costs and values is a necessity. The contributions of practitioners as well as researchers will be invaluable in developing such measures.

In summary, counselors can address the effect of the environment through their work in three ways. In their direct work with clients, counselors can facilitate awareness of the environment, its impact on clients, and ways that clients might more actively challenge the limitations that the environment has placed on them. Group work is one means of promoting such growth. A second way that counselors can be effective is through their own direct participation in the social change process. Professional publications and seminars, political awareness and education efforts, and involvement in the local community are some ways that counselors can be effective. A third avenue for action is through the promotion of an economic framework for planning and evaluating prevention programs. Through analysis of the economic and noneconomic costs and values of programs, the benefits of early prevention efforts will be demonstrated in terms that the American public and funding agencies can appreciate and understand.

Dramatic changes in our society have repercussions that are felt even to the roots of the tree. The situation is more precarious for those roots embedded in rocky and unnourishing soil. Besides patching up bruised fruit, repairing damaged branches, and bolstering weak trunks and roots, counselors must also address ways to improve the soil. As the horticulturist must be concerned with the whole of the tree, so too must we be concerned with the whole of the adolescent at risk.

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Part II

EXAMINING THE CAUSES

Chapter 3

THE HARMFUL EFFECTS OF DYSFUNCTIONAL FAMILY DYNAMICS

Artis J. Palmo and Linda A. Palmo

As presented in the first chapter, the problem of youth at risk is not new; but rather, the use of a new phrase to describe an old problem. The Pennsylvania Department of Education (1987) described the at-risk student as one ". . . who runs the risk of not acquiring the knowledge, skills, and attitudes neded to become successful adults . . ." (p. 1). This description is profound when considering the at-risk youth from a family perspective. If parents have been unable to acquire the "knowledge, skills, and attitudes needed to become successful adults," how destined are their children to be youth at risk? If youth are at risk, are parents also at risk? Can entire families be at risk?

The basic premise for this chapter is that the at-risk behaviors exhibited by the youth are a direct result of dysfunctional family dynamics. As you will note from the case studies presented throughout the chapter, frequently the at-risk youth is a representation of the chaos, disruption, and pain in the family as a whole. Parents, in reaction to the problems presented by the at-risk youth, may attempt to find simple solutions to complex questions, therefore avoiding the possibility of exploring or admitting their own dysfunctional family dynamics to themselves or any helping professional who may be involved with the at-risk youth.

Considering the relationship between family dynamics and the problem of at-risk youth, the goals of the chapter are to: (1) provide an understanding of the effects of family dynamics on the development of at-risk behaviors in youth; (2) discuss the therapeutic treatment of dysfunctional families and individual family members; (3) understand the effective use of referral and consultation with dysfunctional families; and (4) understand the process of assessment with families of at-risk children. By studying the information and discussions presented in these four areas (development, treatment, referral, and assessment), the reader should be able to provide more effective and comprehensive services to those youth identified as being at risk as well as their families.

Developmental Issues

Recent literature (Abbott, 1978; Anderson & Limoncelli, 1982; Kunisawa, 1988; Stevens & Pihl, 1982a, 1982b; Zarb, 1981, 1984) describes a multitude of characteristics, attributes, and reasons for at-risk status. Gadwa and Griggs (1985) categorize these into four areas when discussing the development of at-risk behaviors in youth: family, personal characteristics, socioeconomic factors, and school behavior. Although the Gadwa and Griggs study referred primarily to at-risk status of potential high school dropouts, their categorization can be generalized to all at-risk youth, regardless of the primary presenting problem. Two implications pervade these studies of at-risk youth. First, family dynamics and patterns of interaction are a key reason for the development of at-risk status. Second, the problems and characteristics of at-risk youth are multidimensional and seldom come from only one source.

The interaction of family dynamics and family background with a multitude of other factors provides the medium for the at-risk youth's inappropriate or maladjustive behaviors. The problematic dynamics in the family of the at-risk youth are multidimensional and can range from mild to moderate in severity. But, it is not unusual for multiple problems to exist in the home (Anderson & Limoncelli, 1982). The at-risk behaviors of youth are demonstrated in all types of families: rich and poor, blue collar and white collar, two-parent and single-parent, educated and uneducated. No family is immune to the potential for dysfunctional family dynamics.

Family Influence on Individual Problems

Following the identification of the at-risk youth by the school, community officials, or parents, much attention is often given directly to the youth without commensurate attention to the entire family. Without the involvement of the family in the assessment process it is impossible to understand the true functional level of the at-risk youth. How the youth begins to feel "out of place" within the family (Dinkmeyer, Dinkmeyer, & Sperry, 1987) will certainly influence how the youth feels out of place in the world at large. The problems expressed by the at-risk youth are a direct result of difficulties experienced either overtly or covertly by the family unit. Therefore, an accurate assessment and development of a treatment plan for an at-risk youth must be accompanied by a thorough assessment of the family and an involvement of the family in the treatment.

The at-risk youth is a representative of the family and symbolizes the severity of the difficulties within the family unit. The greater the difficulties demonstrated by the youth, the larger the number of issues that need attention within the family. Although there are examples of at-risk youth with pathologies that do not provide an honest picture of the family's difficulties, in most instances the youth's behaviors are an accurate barometer of the family's stability. A brief case example will demonstrate the above presentation.

> Justin, a 14-year-old freshman, was referred for counseling by the school following a report that he was suicidal. Two of Justin's friends found a letter describing how he planned to shoot himself. Justin, along with his mother and father, came for counseling. It was apparent during the initial session that Justin did not want to be in counseling. He was rude, obnoxious, and embarrassing to his parents. Mother was tearful, while father remained stoic. Both parents were obviously shaken by Justin's recent behaviors. The counselor attempted to assist the family in understanding the relationship between the issues Justin expressed and the problems the family faced. Both mother and father were willing to accept their responsibility for the apparent problems, but Justin refused. Justin claimed that all was well with him *now*, and he no longer needed help and was not going to hurt himself. He "won" because the family did not return for counseling or force Justin to return.
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> In conceptualizing the issues Justin and his family faced, it is possible to understand how the parents "lost" control of their son. Justin was an only child of two very ambitious parents, both of whom worked long hours to provide for the family. On the other hand, his parents perceived Justin as physically lazy, irresponsible, and a failure in school. The parents, however, never pushed Justin to do schoolwork or take responsibility for chores around the house. Because Justin was so resistant, he was able to do as he pleased because the parents no longer wanted to fight with him. He made a plea for their attention with the suicide letter, and once he got the

> attention he desired from the parents, he returned to his previous behaviors. He was now capable of "blackmailing" his parents more effectively than ever before.

The purpose of this brief case presentation is to demonstrate the relationship between the behavior of the at-risk youth and the difficulties the individual family members face. The parents ignored their own needs as a couple to provide for Justin. He was spoiled and irresponsible, and generally ungrateful for what they had been able to provide, *but* quite angry about what his parents were *not* providing. Therefore, this parentified child (Palmo & Palmo, 1988) used the most powerful weapon in his arsenal, a suicide threat, to gain the attention he desired. Justin used the suicide threat as a coping style shortly after the suicide of one of his classmates.

Once Justin received the attention he desired, he was somewhat embarrassed. School officials were involved, his friends were afraid to be with him, the extended family was concerned, and all-in-all he had created a situation where he was never alone. Someone was always watching him. So from a feeling of being ignored by his family and friends to a 24-hour watch of his activities, Justin had come full circle. Now Justin wished for everything and everyone to return to normal.

Justin did not understand how he represented the dynamics of his family. He displayed the insecurity of a father who worked 16 to 18 hours at two jobs, always frightened that he might be considered a failure by his own father. He displayed the loneliness of a mother who desired more from a marriage than she felt she was receiving. Finally, Justin displayed the anger of a child who does not feel loved and therefore cannot love. Assessing Justin's problems without an understanding of his family dynamics would lead to the possibility of an inappropriate treatment plan. The at-risk youth is a representative of the family and displays the discord the family as a whole feels.

Family Dynamics and At-Risk Behaviors

Once the youth demonstrates at-risk behaviors, the family dynamics play a significant role in whether or not the at-risk behaviors will escalate or decrease. If the dysfunctional aspects of the family dynamics are not identified, discussed, and changed, the behaviors of the at-risk youth will continue to escalate. It is common knowledge that conflicts between the parents, whether overt or covert, have a significant impact on the behavior of the children. However, for the at-risk youth, the parental conflict has a compounding effect. Whereas one child in the family may choose to ignore mother and father's problems by spending more time with friends and another by putting excessive energy into school, the at-risk youth finds it difficult to resist potential problem areas. A brief case example will help.

> Jim, a 17-year-old junior, was referred for help because of difficulties at school. He was failing several classes, had been dismissed from classes for misbehavior, and had cut school. Jim was also the star of the high school football team. School officials suspected Jim was drinking heavily during the school year. The family came for counseling, except for the oldest daughter who was attending college. Father was a professional, and mother stayed home to raise the children. Besides the sister, Jim has a brother of 15.
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> At the initial sessions, the parents informed the counselor that Jim had had difficulties for the past 2 years, but they had never sought help. The parents suspected drinking, but felt it was at minimal levels. They also reported that Jim had difficulty following rules at home and basically directed his own behaviors without much interference from either of the parents. Of the three children, Jim was by far the most difficult to raise. Jim's sister was successful at college and his brother was successful in school and was no problem at home.
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> Counseling with Jim and the family over a period of several months proved fruitless. Regardless of the efforts of the counselor and the repeated efforts of the parents, Jim's behavior did not improve, but actually got worse. Finally, after several sessions with the parents, both individually and as a couple, it was determined that the marriage was in severe trouble. Father was having an affair, unbeknown to the mother and family. Mother was significantly overweight and suffering from severe physical problems. The marriage relationship was the core of the family problems. However, when confronted with their marital problems, both parents were unwilling to pursue in-depth marriage counseling to solve their differences. The result of this decision was predictable. Not only did the marriage get worse, but Jim also got worse. He completed his junior year and spent the summer causing difficulties for his parents.

The point this example makes is that the unresolved issues of the parents and family significantly affect the behavior of the at-risk youth. Although Jim's siblings seem to be successfully progressing through their development with relative ease, Jim is having severe difficulty keeping his life in order. As Jim continued through high school he drank more, lost his driver's license for speeding and reckless driving, and was in jail for disturbing the peace. Jim became more and more of a danger to himself, his family, and his friends. During this time, the couple's relationship became more and more of a problem. Father's affair was discovered, although the full extent of the third party relationship was never fully disclosed. Divorce was considered, but little change was occurring at home in relation to parenting Jim.

The dynamics of the couple and family influence at-risk behavior, as demonstrated by the case of Jim. As the youth's at-risk behaviors increase and change, there is always a corresponding change in the dynamics of the family system. The at-risk youth is dependent upon the family dynamics for his or her support and encouragement; therefore, before the at-risk behaviors decrease, the dynamics of the personal interactions at home must change.

One final note must be made about Jim's family that reinforces the importance of understanding the impact of family dynamics on at-risk behavior. First, Jim's sister became very involved with her boyfriend from college and decided to transfer with him to a college 3,000 miles away from home. The move from the East Coast to the West Coast was the daughter's attempt to escape the situation at home with her parents and Jim's constant difficulties. However, the daughter is also at risk for pregnancy, early marriage, not finishing college, and so on. Second, the younger brother, who was very compliant during most of Jim's antics, was beginning to have problems himself. He was disobeying his parents more frequently and got himself into trouble with a neighbor for being a "peeping Tom."

All-in-all, the couple's difficulties, basically not known on an overt level by any of the children, caused the children to respond in their own way to receive the attention they desired. The family dynamics are an important determinant of the level of at-risk behavior exhibited by all of the children, not simply the youth identified as being at risk.

Development of Dysfunctional Family Dynamics

The development of dysfunctional family dynamics produces an at-risk youth who in turn exposes the dysfunctional family dynamics to the community. If the family's problems do not begin with the at-risk status of their son or daughter, as exemplified in the previous two case studies, how does a family become dysfunctional? The development occurs over a long period of time and is the result of numerous unresolved issues and problems.

The roots of dysfunctional family dynamics rest in the family of origin of the mother and father of the at-risk youth. The models they were shown in their own families will have a driving influence on what they do or do not do with their own children. Unfortunately, many of the tactics used by parents in the past need to be adapted to today's world and today's youth. If the mother and father of the at-risk youth lack the self-awareness of how they have been shaped by their own families of origin, they will be unable to adapt their parenting style. The ability to develop successful family dynamics comes from a true understanding of the parents' own positive and negative development as children. The parents' ability to appropriately and accurately see themselves as members of their own family of origin will influence their children's ability to appropriately see themselves as members of the current family.

The development of dysfunctional family dynamics can also be rooted in an unhealthy marriage. The dynamics between parents are the precursor to the dynamics between parent and child. If a couple does not develop appropriate coping styles for resolving conflict and honest, open communication patterns in their marriage, they are at risk to parent at-risk youth. The ability to process marital conflict is essential to be able to process parent-child conflict issues. Often parents are more willing to address problems with their children than problems with the marriage. If parents are unwilling to address their own problems, their children will be unwilling to address their inappropriate behaviors.

Dysfunctional family dynamics can also occur when roles and responsibilities are not effectively defined in a family. At-risk youth have one common characteristic—regardless of the identified problem behavior, they all violate the established rules of the home, school, or community. The violation of standards and structure begins early in life and early in the development of family dynamics. If the parents do not agree on parenting responsibilities, then discipline, rules, and responsibilities will be poorly defined in the early development of the children. Because of the parental conflict, the child becomes parentified early in life. The child is often given major choices early in life and asked to direct his or her life appropriately. Without a sense of structure, the child seldom understands what "appropriate" means. Ultimately, the at-risk youth may split the parental conflict even further through his or her acting-out behaviors.

One note of importance when examining the development of dysfunctional family dynamics is the issue of stepfamilies. Frequently, we treat at-risk youth who are members of a new, restructured family unit. It seems, at least on the surface, that the at-risk behaviors are a result of the new family structure; however, further exploration of the at-risk youth's background will typically show that the problems were exhibited prior to parental divorce and remarriage. The losses that occur at the time of divorce and the changes necessitated by a restructured family frequently provide the youth the impetus to exhibit critical at-risk behaviors.

In summary, the development of dysfunctional family dynamics provides fertile ground for the development of at-risk youth. At-risk youth exacerbate dysfunctional family dynamics. The assessment of family dynamics is not simply a black-or-white, good-or-bad, appropriate-or-inappropriate evaluation. There is a continuum of functional to dysfunctional family dynamics that may be evaluated at different levels of achievement depending on the time, the place, and the stage of development of the family members. When a family member is identified as an at-risk youth, it is credible to assume that the family is experiencing and will continue to experience increased dysfunctional relations among and between family members. It is highly significant to note that "fixing" the at-risk youth will not typically "fix" the dysfunctional family dynamics. Also, just as the problems develop over a long period of time, it will take a long period of time to solve the problems.

Levels of Dysfunction in the Family

When assessing the level of dysfunction in the family and the level of risk the youth exhibits, it is possible to classify families as either severely or moderately dysfunctional. The extent and type of treatment to be used with the family depends on the severity of the dysfunction in the family. Severely dysfunctional families usually are identified easily whereas many moderately dysfunctional families become expert at covering family difficulties. The following discussion will provide some distinctions between the two groupings.

Severely Dysfunctional Families

In the severely dysfunctional family, the at-risk youth is predictable because of the severe dysfunction of one or more adults in the family. The adult(s) in the family may have been dysfunctional in the past or may presently exhibit many at-risk behaviors. For example, the adult(s) may have a poor work history, a criminal record, or a history of substance abuse. Frequently, the behaviors exhibited by the at-risk youth are identical to those exhibited by a parent at some point in his or her life. For example, the pregnant teenager often has parents who had to get married; the suicidal youth may have had a parent or grandparent who tried to commit suicide; or the anorectic young girl may have a mother who was or may still be anorectic.

Underlying all of these difficulties and at-risk behaviors is a lack of rules and personal boundaries on the part of the adults as well as the youth. Frequently, the adults have fewer boundaries than the children, with the children acting in the role of a parent to their own parents. Parents who use drugs in front of the children, come home drunk, and don't go to work often have children who have not been attending school, have been caught with drugs, and are failing the 11th grade. Treating the at-risk youth has to involve treating the parents of severely dysfunctional families. The parents will have to face their problematic behaviors before the at-risk youth can face his or her problems.

Rules and personal boundaries are the issues to be considered in assessing the severity of the problems the at-risk youth and dysfunctional family exhibit. The higher the level of difficulty with rules and boundaries, the greater the level of risk and dysfunction. In addition, the more difficulty the adults have with rules and boundaries, the greater the risk for the youth. Therefore, the adult who constantly abuses drugs and alcohol has little understanding of the importance of basic daily responsibilities and parenting. The at-risk youth has a difficult time finding apporopriate role models in the home where he or she lives. The youth perceives mom and dad as constantly repeating, "Do as I say, not as I do!" Treatment with severely dysfunctional families is difficult. If the parents cannot or will not participate in changing the problematic family dynamics, the prognosis for improvement of the at-risk status of the youth is poor.

Moderately Dysfunctional Families

In the moderately dysfunctional family, the at-risk status of the youth is more difficult to discern and is not so readily apparent to the outside world. The personal profile of the at-risk youth is more dificult to interpret because of the seeming stability of the family. Each parent presents an appropriate image to the outside world; therefore, it is difficult to believe that there may be severe problems with one of the children. Below the surface, hidden from the community view, the family has difficulties it is not willing to reveal. The at-risk youth becomes the not-so-popular messenger, letting the comunity know that the family has secrets and is not perfect. There are flaws in the family photo, and the picture glass is cracked!

The advantage to the professional treating the moderately dysfunctional family is that the adults are typically able to function pragmatically on a day-to-day basis. Usually, they are competent in dealing with their job, pay their taxes, and generally follow the rules. However, as shown in the brief case history of Jim, the father had difficulty following the rules of marriage while mother had great difficulty following the rules of sensible eating. The prognosis for the youth from the moderately dysfunctional family is better because the parents can more easily change some of their own behaviors, including parenting skills. The greatest problem is having the parents accept their portion of the responsibility for the dysfunctional family dynamics and not keep the focus solely on the youth.

Patterns of Behaviors in Dysfunctional Family Systems

After discussing the importance of family dynamics, the development of family dysfunction, and the evaluation of family dysfunction, it is most appropriate to utilize those concepts to present specific patterns of behavior in dysfunctional family systems with at-risk youth. By integrating the interaction of the dysfunctional family and the at-risk youth into six specific patterns, it is possible to present case examples, discuss typical therapeutic problems, and suggest treatment interventions and modalities.

At-Risk Adults Parenting At-Risk Youth

Probably the most important information that can be gathered at the time the at-risk youth is identified is the complete history of the family members, especially the parents. Frequently, the knowledge of the pathology the parent or parents in the past have exhibited can be helpful in the diagnosis and treatment of the youth. The adult at-risk behaviors seem to be transmitted directly to the children. Although the behaviors of an at-risk youth may be different from an adult's at-risk behaviors, the goal of the behavior remains the same—direct or indirect self-destruction (Farberow, 1980). The adult's self-destructive tendencies are not always suicidal, but rather entail making decisions that are not personally or professionally productive.

There are numerous at-risk behaviors that adults demonstrate to their children, and certain behaviors in their past tend to influence their interactions with the youth. Those adults who exhibited at-risk behaviors as teenagers, such as alcohol abuse, pregnancy, or eating disorders, frequently find themselves faced with offspring demonstrating similar, and at times, identical at-risk behaviors. It is not unusual to find that a pregnant teenager's mother was also pregnant as a teenager.

For the case presentation we will discuss Bill, a 16-year-old referred by the school for poor grades and suspected drug and alcohol abuse.

> Bill came to the first session with his parents and presented himself as the basic noncompliant teenager. The parents, both from upper-class backgrounds, were quite concerned about Bill's academic problems as well as the difficulties they were having with him at home. Not only were there difficulties with school behaviors, but with even more severe problems at home. The parents found that Bill had been drinking, rather heavily, and most recently was brought home by the police for shoplifting at a mall near their home.
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> Although the family, including a younger sister of 14, were willing to attend the counseling sessions, not much change occurred during the initial stage of the treatment process. In fact, there were more drinking episodes, late night outings, and more shoplifting. Finally, one Saturday evening, Bill and his parents had a tremendous physical fight and argument at home that was reported to the counselor by Bill's sister. As suspected throughout the treatment process, both parents were heavy drinkers, even though both minimized their drinking when confronted by the counselor throughout the treatment process. This particular Saturday night, both had had too much to drink and found themselves in a brutal confrontation with Bill.

This particular case example demonstrates several important points. First, the parents had a severe drinking problem that directly affected the behavior of their at-risk son. Bill, like his parents, used drinking to escape his problems, avoid changing, and find excitement. Second, through shoplifting, Bill was able to inflict embarrassment on his financially successful parents. What better way to embarrass his family than by shoplifting, a poor school record, and drinking! Bill brought the family secrets to the surface for everyone to see.

When assessing an at-risk youth like Bill, the professional must examine the adult family members to determine possible at-risk behaviors that may be hidden from the community view. In this case, although both parents were highly successful in the professional and social arena, they both had drinking problems and came from families with alcohol abuse. Bill chose to use the at-risk behavior that had been used by his parents and their parents. Family history is crucial when assessing and treating at-risk youth.

During the treatment process, the professional has to encourage the parents to face their alcohol dependency before the at-risk youth can begin to change. In the case of Bill, once the severity of the parents' drinking surfaced, the couple was willing to admit to their problem and seek counseling services for themselves. Once the couple began to examine their relationship and interactions, parenting Bill became a reality.

One final point about this case relates to Bill's sister. She became the parent and protector for Bill, very much at risk for a variety of potential problems herself. Therefore, everyone in the family needed counseling assistance to learn new patterns of interaction, to trust one another, and to support each other. Besides the identified at-risk youth, a sibling also may be having severe difficulties.

Interestingly, the transmission of at-risk tendencies from parent to child is much easier to assess with severely dysfunctional families. The at-risk tendencies become hidden in moderately dysfunctional families; therefore, the mental health professional must be astute and persistent and constantly probe to find the hidden at-risk behaviors of the adults. The lawyer and his wife, the professor and the saleswoman, or the successful business owner and his professional wife are not going to admit to their problems as easily as those families with known histories of alcohol or drug abuse, child abuse, and so on. It is extremely important to interview all members of the family thoroughly for the possibility of at-risk behaviors once an at-risk youth has been identified.

Parental Conflict and the At-Risk Youth

If parents are having difficulty processing conflict between themselves, the situation is likely to deteriorate into communication problems between the parents and extend to communication problems between parents and child. Secrets begin to exist between the parents, and the at-risk status of the child may be hidden from view by the poor communication of the parents. For example, one parent may know that the youth is failing a subject or drinks beer with his friends, but keeps this information a secret from his or her spouse. Obviously, the distrust between the parents creates an atmosphere where the children can manipulate one or both parents, but more importantly, the lack of respect between the parents is carried into the relationship between parent and child.

The conflict between parents leads to power struggles in parenting the child. Each parent attempts to structure his or her relationship with the child as an individual instead of as a member of the marital unit. Loyalty issues are pressed onto the child. For example, a teenager comes home after curfew and is grounded for 1 week by the father. After 2 days mother allows the teenager to visit friends but says, "Don't tell Dad!" This pattern of deceit between parents empowers the at-risk factors for the youth in two ways. First, the youth learns not to follow rules.

and second, the youth learns to be deceitful. The problems increase when the at-risk youth begins to encounter difficulties at school that pattern the problems of the parents at home. No longer can secret communications be used, and the family dysfunction appears for others to see. A case example will demonstrate the point.

> Ellen is a 15-year-old high school sophomore who was referred for treatment because of difficulties at school as well as home. The family consisted of mother, father, son, and Ellen. As Ellen would later report, her brother was Mr. Perfect, who never got into trouble. In the meantime, Ellen was failing various subjects at school, had been placed on curfew at home, and had been in difficulty in the local neighborhood. The culmination of the difficulties with Ellen occurred when she was involved in a teenage drinking party at her friend's house. At this party several of the teenagers became drunk and destructive, doing a great deal of property damage. Before Ellen and her friend could correct all of the problems, her friend's parents came home. Needless to say, both Ellen and her friend were severely punished and not allowed to see one another anymore.
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> After the "dust had settled," Ellen and her friend decided to run away with two other male friends from school. Because both of the girls had been leaving the house secretly without their parents' knowledge for the past year, sneaking away was not a difficult task. They locked their rooms before leaving, making sure their parents knew they were in the room, and ran off to a wooded area for 2 days. After 2 days, being hungry, they returned home. The parents were both relieved and angry.
>
> During the counseling with the family, it became apparent that the communication patterns between and among the family members were ineffective. The family had moved on several different occasions because of job changes for Ellen's father. Ellen's anger at moving was known to the father, but not his wife's anger at him. Therefore, Ellen and her mother frequently had long, personal discussions about their desire to return to their previous home, but they never disclosed the intensity of these feelings to the father. In addition, Ellen's mother allowed her to smoke in front of her, drive the car without a license, and break her curfew without punishment. The close and inappropriate relationship between Ellen and her mother made it difficult to change Ellen's at-risk behaviors and kept father

> "in the dark." The parental conflict over moving formed the basis for dysfunctional family dynamics and the at-risk status of Ellen. This case example points out two important areas.

First, it is almost impossible to discipline a youth having severe difficulties without complete cooperation between the parents. If the couple's relationship is not sound, parenting is a real difficulty. One parent undercutting the effectiveness of the other makes it impossible to bring about change. Therefore, the mental health professional must make sure that the family secrets between a parent and youth are known to the other parent, or the professional may find that a great deal of time is spent in counseling with little change occurring.

Second, loyalty issues between family members can create severe problems if the loyalty lines are inappropriately drawn. In the case example, Ellen's mother's loyalty was to Ellen and not to her husband. The appropriate loyalty for the couple's interests must be between husband and wife first, then parent and child. In the above example, the inappropriate loyalty on the mother's part created a system where the youth had parity and equality with the parents. Giving an at-risk youth that type of personal power in the home results in problems for the parents as well as for the youth. The role of the family counselor is to promote and assist the parents and the youth to develop appropriate loyalties and also to reinforce the need for the youth to follow established rules.

One final note needs to be mentioned about the difficulties created by divorce and the impact on the behaviors of the at-risk youth. To oversimplify a difficult and complex problem, let us say that a divorce happens when two people fail to communicate and resolve conflict. Following divorce, if a youth begins to exhibit at-risk behaviors, it usually takes a significant problem to force the parents to face the severity of the issues. If two people cannot communicate and resolve conflict while they are married, then why would anyone expect them to communicate and resolve conflict when they are divorced? The number of secrets both parents have kept is typically enormous because neither wants to be the parent that is accused of being inadequate in the care of the youth. Therefore, by the time that the at-risk youth is referred for care, the problem is usually critical.

In treating the youth of a divorced couple, it is important to remember to involve all important adults and children. The cooperation of all adults in the treatment process is a must if the youth is to improve and move beyond at-risk status. Without the involvement of both parents, and the stepparents when the two individuals remarry, the secrets, loyalty battles, and rule breaking will continue. The goal of therapy becomes consistency in treatment of the at-risk youth, without reinforcement of the youth's manipulative behavior. Each parent, in his or her own home, must establish a set of rules, appropriate consequences, and appropriate rewards that satisfy the needs of the youth and the parent and stepparents. Consistency and congruence are the two words most often used in the cases involving divorced couples. They do not need to agree on the methods used in each other's home, but they must commit to being consistent and congruent within the parenting system developed in their own home.

Family Denial and the At-Risk Youth

The defense mechanism of denial consists of a process of not seeing problems or their intensity. During times when problems become evident, denial allows people to blame others rather than themselves. Therefore, denial is acted out in two ways in families. First, denial can be displayed by "burying one's head in the sand," not wanting to see the reality of the situation. Second, denial is displayed by "finger-pointing," blaming others for one's problems. Both ways of using denial lead to the potential for at-risk youth in a family. A case example will demonstrate the points.

> Jeff, a 17-year-old junior, was referred to counseling by the school psychologist for not attending classes. Jeff had had difficulties for the past 2 years in attending school, but because of his brightness, he was able to pass to the succeeding grade through the help of home-bound instruction and tutoring. However, by the time Jeff was brought for counseling in November, he had already missed 6 weeks of school. Jeff's parents had been divorced for 10 years, with Jeff residing with his mother and having very little contact with his father, who had moved to another state. Mother did not remarry, but father did.
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> After meeting Jeff and his mother, it was apparent that the relationship between the two was more like that of a husband and wife, rather than a son and mother. Jeff directed his life the way he desired, and although mother attempted to discipline him, he continued to do as he pleased. Later, after numerous attempts, the father came to one of the counseling appointments. He felt Jeff did not need therapy, but a "good kick in the seat of the pants," which the mother was not doing. In addition, the father told Jeff that he would give him money if he corrected the problem of not attending school.

Assessing all three characters in this drama demonstrates that Jeff, mother, and father all suffered from a poor level of self-awareness of their impact on the problems exhibited. What was worse, none of the three wanted to accept responsibility or take partial ownership for the problems or make any attempt to resolve the issues. Ultimately, Jeff did not complete school, but was dropped from the school rolls.

The case of Jeff is a real tragedy. A young man with many talents who did not finish school, he chose to work at a service station pumping gas. Jeff and his parents had low levels of self-awareness and were unwilling to begin a concerted effort to correct a problem with a long history of frustration and failure. Both mother and father blamed each other, and Jeff blamed mostly himself, but at times felt his mother was the culprit. Regardless, all the parties involved used denial to avoid resolving the problems, with the ultimate victim being Jeff, a high school dropout.

It should be noted that denial is a common problem when counseling the at-risk youth and the family. It appears frequently with cases involving alcoholism, drugs, sexual promiscuity, and divorce. The helping professional is forced to proceed at a slow pace in an attempt to reduce the defensiveness and denial, in order to serve the at-risk youth. At times, the slow pace creates a therapeutic dilemma because the at-risk youth may need assistance more quickly, but the family's denial system is so strong that a severe problem has to arise to make the family face its problems. The severe problem can be an auto accident, drunk driving, a suicide attempt, school failure, and so forth. Counselors have to be patient, but constantly on the alert for the signs that the at-risk youth may give that indicate greater problems for the future. Sadly, at times, the denial will cease only following some type of personal tragedy of the youth.

The Parentification of Children and At-Risk Youth

One pattern of dysfunctional family dynamics that begins in the early years of child development is parentification of children. The pattern is related to parents who give responsibilities and privileges to younger children that would be more appropriate for older children or adults. The young children, by their actions and requests, maintain the control of the household and frequently dictate the mood of the entire family. Parents, fearful of disrupting the family calm, refrain from effective discipline techniques, allowing the child to have control of the family. A brief example will demonstrate a young child's power of blackmail.

> Kay, a 10-year-old, was referred for treatment by her mother and stepfather for serious behavioral difficulties at

> home. Kay did not listen to her mother and objected vehemently to any attempts at control by the stepfather. Parents reported that Kay would not eat supper without some type of behavioral outburst that disrupted the meal for the entire family. In addition, whenever Kay was asked to do a task, like make her bed or do homework, she frequently became belligerent and upsetting. Needless to say, the family became very careful to not upset Kay and used bribery or whatever was necessary to keep her calm. Also, whenever major decisions were to be made regarding Kay's life, such as choosing a school, a doctor, or a vacation, she was given as much power as the mother and stepfather. In this way, the parents felt Kay could learn to be responsible for her life and make decisions that would keep her happy and calm. Kay used this power to blackmail her family by refusing to do things she disliked unless they gave her her own way. "You let me go over to my friends and I won't throw a fit at dinner!" At dinner she threw a fit, regardless of whether or not she got what she wanted earlier.

The intent of the example is to show the tremendous power children can gather through ineffective and inconsistent parenting techniques. The child, through the process of blackmail, controls the house. Later in life as the child approaches the teenage years, the extent of the control is massive. The at-risk youth begins the journey to difficulty as a very controlling and manipulative young child who has been given the power to make decisions that should be joint decisions of the parents and the child.

On the other side of the coin, a child can carry the burden of maintaining the well-being of the entire family. As long as the child is behaving well, giving attention to the parent or parents, and causing no apparent difficulty, life is fine. However, the child entrusted with this responsibility carries tremendous power and control. The burden can become intense as the child grows and matures. It is tiring always to be happy, provide love for a parent, care for the other children, and be an adult. The parents report that the at-risk child has never been a difficulty, but the ideal child who takes care of himself or herself and those around them. The parent never realizes the burden of such responsibility.

Children and youth want to be in control of the decisions that affect their life and will take every opportunity to gather more power. Parents must be encouraged to involve their children in the decision-making process, but be reminded that involvement is different than making a final decision. The final decisions in the life of the child or adolescent belong to the parents. At times, parents want their children to be miniaturized adults, and are pleased when the child behaves like an adult. However, the parents need to be reminded that the children need to act in an age-appropriate manner and what may be "cute" now, may not be appreciated in the future.

Intrusive Parents and the At Risk Youth

The intrusive parent gives the youth absolutely no privacy, checking everything from the mileage on the car to his or her bedroom belongings for clues of the youth's inappropriate activities. Typically, the intrusiveness begins when the youth has broken the trust of the parent-child relationship by being caught with marijuana, drinking, stealing, lying, or coming home late. After one or two of these "crimes," the youth's life is no longer private, but a public domain. In some instances, checking on the youth for possible signs of acting out that can be dangerous to the youth's well-being is appropriate. However, the intrusive parent goes far beyond simple observing to checking pockets in dirty clothes, going through notebooks from school, checking mail, reading notes from friends, and so on.

Frequently, the cautiousness and concern for the hidden aspects of the youth's life are directly related to the status of the parents' relationship. The parents do not trust each other and maintain a life that is exemplified by lies, deceit, and secrets. The following case example will demonstrate the dysfunctional dynamics.

> Jenny was a 16-year-old sophomore who was referred for counseling because of poor academic achievement and difficulties at home in following the disciplinary actions of her parents. One of the difficult issues for the parents was Jenny's friends, who they determined were inappropriate for Jenny and were the cause of all her problems. She was in frequent disputes with her parents over dances, trips to the mall, or any activity that she might attend where her friends could possibly be. Jenny's mother, in an attempt to curb her inappropriate activities, would read her notes from friends, monitor phone calls, keep track of the mileage on the car, and follow her when she left the house.
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> The parents were resistant to pursue counseling for themselves, expressing that the issues were Jenny's and not theirs. However, during a brief consultation with Jenny's mother it was learned that mother had had an affair of long standing that had recently ended. Father was unaware of the problem;

> however, her mother had told Jenny. Although the parents knew their relationship was in serious difficulty, neither would commit to couples counseling.

The above case demonstrates the severe problems involved when the parent or parents become overly intrusive in the child's life. Typically, the intrusive parent has difficulty in establishing appropriate boundaries between him- or herself and the children. In this case, the mother gave the daughter very little distance on the one hand while on the other she shared inappropriate information with her about her private life and relationships. It is clear that the at-risk youth armed with such powerful information about a parent can cause serious and continuous disruption in the family.

In addition, as demonstrated by both parents in this example, there is an overemphasis on the parent-child relationship with too little attention given to the parent-parent relationship. The at-risk youth becomes an extension of the conflicts between the parents. The parents refuse to deal with their issues, becoming overinvolved in the youth's difficulties. In the meantime, the youth is attempting to force the parents to deal with real issues surrounding their marriage.

Along with having difficulty with boundary issues, the parents attempt to protect the youth from the natural consequences of his or her actions. The protective nature of the parents arises from the guilt they feel about the lack of stability in their marriage, from the ineffectual way they have handled their life, and from the failure they feel as parents. Whenever the youth has a problem, the parents attempt to fix it rather than letting the youth suffer the consequences for his or her actions. Parents will complete homework, pay the cost of damage to cars, and lie to the school about absences. Parents model the exact behaviors for which they are criticizing the youth. The youth is taught to "do as I say, and not as I do."

Serious Illness of a Parent and the At-Risk Youth

The final family system to be discussed relates to those families where one of the members has a serious illness, such as leukemia, kidney failure, heart problems, or similar life-threatening problems. Within this family structure and communication system, the family never completely discusses the problem or is open about the extent of the difficulties the problem may cause the individual or the family. For example, a youth may learn from his biology class or health instructor that the serious heart ailment his father suffers has a genetic link. If the family has not discussed the future implications with the children, the impact of such information on the youth can be traumatic. The youth, upon learning such crucial information, is someone who must be considered at risk.

The lack of communication about the serious illness promotes a family system that on the one hand is based in secrecy, deceit, and dishonesty, while on the other, is emotionally charged. Family members tend to overreact to simple problems, parents are protective of the children, and in general, the entire family is oversensitive. However, the sensitivity and emotionality are related to the serious illness, which is rarely discussed, while the attention is placed on less serious problems and concerns. Denial is a major aspect of the dysfunctional family communication system. The following case will demonstrate some of the difficulties the treatment of the seriously ill client presents.

> Mary, a very bright and gifted high school student, was brought to counseling because of concern about potential suicide. Her parents had been seen for counseling for several months because of the serious difficulties the father was having because of kidney failure. He had been on dialysis for some time, and the prognosis was not good. His life expectancy was less than 6 months. Both mother and father were attempting to come to peace with his eventual death in the near future. In the process of coming to terms with the problems, the parents were overprotective of the children, refusing to discuss the seriousness of the father's illness in an open and honest fashion.
>
> Mary presented herself as a depressed youth who was taking an existential view of life and death. One of her beliefs was that the meaning of life was defined by death. Mary had very little information about her father's illness; however, she could be susceptible to the illness as she got older. There was the distinct possibility that she would inherit the same difficulty as an adult. The mysteriousness surrounding her father's problems created an atmosphere of depression, death, and sadness that Mary seemed to absorb like a human sponge. She was not sure why she felt the way she did, but an observer could see that she was the family's emotional leader.

Once the family began to discuss openly the seriousness of the father's illness and his impending death, Mary's serious at-risk behaviors began to subside. She was able to be supportive of her parents, begin to examine her potential problems, and plan for the future while both parents were still alive. The secretiveness that is inherent in a family like Mary's will tend to create many problems for all the family members, not only the seriously ill member. Although it can be frightening to discuss such severe problems with the children, it is a must. Before the death of the ill family member, each other family member needs to be given the opportunity to present whatever they want to the ill person and vice versa. Obviously, this interaction frequently needs to be mediated by a professional, but it a good way to relieve the pressures the entire family feels.

In the case of Mary, following the death of the father, the family continued in counseling. The entire family was better able to discuss the loss, make plans for the future, and begin life without the father. Without the openness displayed by the parents and children, resolution of the death would not have been possible, especially for Mary. Being relieved of the family's emotional burden permitted Mary to grow, develop, and progress through high school as normally as possible for someone suffering such an emotional loss.

In summary, there is much overlap across the six patterns of behavior that have been discussed. The interaction between dysfunctional family dynamics and at-risk youth is complex and multidimensional. This is because human behavior does not readily lend itself to categorization and simplification. The goal of the discussion is to provide helping professionals with some cues that may be of use with at-risk youth and their families. It is important to see at-risk youth as a product of their family dynamics.

Role of the Helping Professional

The role of the professional, whether employed in a school, agency, or private practice, is important and well-defined. In working with the at-risk youth and dysfunctional family, the mental health professional must be sure to "follow the rules" of the treatment process. Just as the at-risk youth attempts to alter the rules in other settings for personal gain, the youth will attempt to have the professional alter, change, and ignore the rules of the treatment process.

For example, the youth may have a simple request, such as asking the professional to write an excuse that would allow him or her to miss a class at school or be permitted to miss detention. Other, more critical violations of the rules may be requests for emergency appointments late at night or over the weekend. One high school principal from a rural district spent 6 hours with a youth along a country road following a phone call requesting her help. It was very considerate of the principal, but also very risky and ethically questionable. The youth would not follow the rules, and the principal reinforced the breaking of the rules.

If an at-risk youth needs help, it is the professional's responsibility to determine the most appropriate treatment for the youth. Meeting a suicidal youth on a country road at 10 o'clock at night is not an appropriate treatment process. Following the rules means having a crisis team available to give the youth the appropriate treatment, and possibly hospitalization. If the youth is really suicidal, then a coordinated professional effort needs to be utilized to resolve the problem.

Basically, professionals need to follow the rules, just as they advise their clients. Not following the accepted professional process places the client in a precarious position and leaves the professional vulnerable. But even more importantly, at-risk youth do not like to behave in typical ways; therefore, the professional must not behave like the youth's family system that permits the youth to continue to violate requirements that others follow without question.

Determining Level of At-Risk Behavior

The first responsibility of the professional is determining the severity of the at-risk youth's actions and interactions. Whether the youth is abusing alcohol, is pregnant, or is a runaway, the professional needs to determine the extent of danger to the well-being of the youth. With youth, we take very few risks, because they tend to be impulsive in their actions and prone to hurting themselves physically. Professionals tend to follow a process that involves three basic aspects (Palmo & Palmo, 1988).

Duty to warn. If the at-risk youth is a danger to him- or herself or others, ethically and legally the parents *must* be alerted to the extent of the problem (Palmo, Langlois, & Bender, 1988). At the initiation of counseling, the at-risk youth and the family are both informed that any suspicious or questionable behaviors will be reported. Confidentiality and at-risk status are both clearly defined early in the process, reinforcing the professional's responsibility to follow the rules. If there is a question about the level of severity of the behavior the youth exhibits, professionals need to follow a very cautious route and involve the parents. The sooner the at-risk youth and the family are involved in treatment, the greater the opportunity for successful resolution of the problems.

Parent consultation and encouragement. As mentioned in the previous section, the parents must become actively involved in the process of treatment as soon as possible. Providing an effective consultation with the parents will assist the family in understanding the necessary steps of the treatment process. It is very important for the professional making the initial contact, whether a school counselor or community mental health counselor, to provide the family with a clear understanding of the helping process. The initial consultation should be used to encourage and assist the family in receiving the most effective services possible. If the initial consultation is a positive experience, more than likely the family will be ready to pursue the necessary steps of the treatment process.

Referral. Finally, if the professional cannot provide the family with the appropriate services, he or she must refer the family to an appropriate agency, institution, or private practitioner. Frequently, the at-risk youth is identified by school officials, but the services required for treatment are offered elsewhere. Therefore, the schools must develop comprehensive referral relationships with local agencies, practitioners, and hospitals (Palmo & Palmo, 1988; Palmo, Langlois, & Bender, 1988). Networking among all community mental health professionals is a must for the successful treatment of at-risk youth.

The three aspects of the professional's role outlined above are important. Each mental health professional needs to understand the principles underlying the concepts of duty to warn, consultation, and referral. Treating at-risk youth and their families requires a complete understanding of these three concepts.

Treatment Modalities

When examining the treatment possibilities for at-risk youth, two important assessments must be accomplished. One is the assessment of the youth and the other of the family structure, dynamics, and functioning. We firmly believe that the most effective approach to treatment during the time that the youth is most at risk, that is, suicidal, involved with drugs, or pregnant, is a combination of family and individual counseling. For most cases we use the combination of individual counseling of the youth while at the same time undertaking family counseling. Remember, the at-risk behaviors are the direct result of the dysfunctional family system; therefore, some aspect of the treatment should involve the family.

There are exceptions to the basic rule of using family counseling as the primary treatment modality. For example, when the at-risk youth becomes too great a danger to him- or herself, hospitalization may be the primary treatment of choice. More than likely, however, the most frequent reason to choose another treatment modality arises when the level of dysfunction in the family is so great that effective family counseling is almost impossible. When the relationship between the couple is questionable, the parenting skills are almost nonexistent, one parent is an alcoholic, or the parents are frequently absent from the home, developing an effective treatment plan is difficult if not impossible. A brief case example will demonstrate this.

> Mark, an 18-year-old senior, was referred for counseling on two different occasions, both following behavioral outbursts at school, followed by outbursts at home. He was brought to counseling by his mother because the father was absent from the home for weeks at a time due to work responsibilities. Each time Mark came for counseling additional appointments were scheduled with the mother for the two of them. However, when the appointment arrived, neither came for counseling. Mark's violent temper and tremendous mood swings had been occurring since he was a young boy. The family had involved the police as well as the neighbors on several occasions, but the parents would never commit to counseling on a regular basis. Mark had attempted suicide by hanging the summer before school started, but even that incident did not bring about a change in the family's attitude about counseling for Mark.

The above case demonstrates that it may not be possible to provide the most desirable treatment for an at-risk youth because of the problems presented by the dysfunctional family. In Mark's case, the school psychologist took over the primary counseling role, because the only time Mark could be seen for treatment on a consistent basis was during school hours. The unwillingness of the parents to accept the responsibility for the care of their child often makes family treatment an impossibility.

Couples Counseling

Frequently, one of the most effective treatment modalities to bring about change in the youth is couples counseling. If the parents can commit to working on their relationship, along with being willing to learn different parenting approaches with their children, the chances of successfully assisting an at-risk youth increase significantly. As demonstrated throughout the case studies, frequently there is such disarray in the relationship betwen the couple that it is understandable why the youth may be having emotional difficulty. Parents who work too much, drink too much, or allow their lives to be out of control provide an inappropriate model for the developing youth. Once the parents can be taught to reorient and redirect some of their energies, the positive changes in the youth are absolutely astounding. Therefore, couples counseling along with family counseling can produce tremendous changes in the dysfunctional family structure.

Networking

Probably the most important professional responsibility for the counselor treating at-risk youth is maintaining a comprehensive referral network of helping professionals. This should include both medical and nonmedical mental health service providers. Referral sources need to include psychiatrists, drug and alcohol counselors, clinical psychologists, marriage and family specialists, and in some cases, the clergy. The professional treating at-risk youth must be an integral part of the school and community in order to provide the most comprehensive services possible.

As presented in a more comprehensive form elsewhere (Palmo & Palmo, 1988), we believe that professional networking is the only effective method for treating the at-risk youth. Because the at-risk status can be defined in many varied ways, the mental health professional must have an effective network of other professionals in order to offer the youth and the family the best services possible. Networking is a safeguard for the clients as well as the professional.

Recommendations

There are several final recommendations to consider when determining the treatment process for at-risk youth. As the counseling professional approaches the treatment of the at-risk youth, he or she must always remember to involve the parents. In some cases, the parents may need to be the primary focus of the treatment process before changes can occur in the youth. In any case, comprehensive services must include the parents in the treatment process.

A second recommendation for each professional is to be totally schooled in the ethical and legal aspects of treating at-risk youth. Each professional needs to be fully aware of his or her responsibility to the youth and the youth's family. The Corey, Corey, and Callanan (1988) text presents an excellent overview of the issues and concerns involved in treating at-risk clients. Another aspect to consider in treating at-risk youth is confidentiality versus keeping dangerous secrets. Too often professionals maintain confidentiality without considering the ramifications to the client as well as to themselves. Being direct and "upfront" with the youth about the types of information and behavior that are treated in a confidential manner versus those to be reported to the parents helps avoid potential problems later in the treatment process.

In treating the family, the professional must maintain a neutral position and avoid being in a position of being on someone's side. The youth and the parents will both attempt to enlist the counselor's support in their attempts to maintain the dysfunctional family system. Phone calls by the youth or a parent, bringing damaging evidence to the session to demonstrate someone's problem, or asking for additional sessions is representative of some of the "influence peddling" family members try. No matter what the individuals attempt, the professional must maintain a neutral status and support the development of a new and functional family interaction system.

Finally, in order to treat effectively the myriad difficulties at-risk youth and their families present, the professional must maintain a high level of self-confidence. Treating at-risk youth and their families can be a substantial test of the professional's self-confidence; therefore, appropriate attention must be given to taking special care against stress, anxiety, and maybe even burnout. Each professional must make a commitment to his or her own mental health in order to maintain the energy needed to treat the at-risk client. Using professional colleagues for support and consultation, making effective and necessary referrals of particularly difficult cases, and seeking personal counseling when the stress becomes too great are some ways a professional can maintain a high level of self-confidence and effectiveness.

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Chapter 4

BODILY ASSAULT: PHYSICAL AND SEXUAL ABUSE

Robert H. Rencken

Why? The question is asked again and again.

Why is the fragile shell of childhood cracked, broken, shattered by abuse?

Humpty Dumpty is pushed off the wall. Who can put him together again?

The complexity and pervasiveness of physical and sexual abuse swirl before us, almost daring us to try to arrest it. Both causes and effects are insidious and intangible; barely discernible at times and devastating at others. We look at the troubled or at-risk youth with one eye and see a victim; with the other eye we see an actual or potential offender.

The complexity of the problem, in fact, obscures our ability to adequately define and quantify it. What is abuse? Who is the victim? Where are the limits? How bad is bad? Who reports what to whom? The impact of abuse is difficult to measure because of varying incidence factors (particularly reporting differences) and varying effects. These effects may be felt immediately after the abuse or not until weeks, months, or years later. As the reader will see in this chapter, physical and sexual abuse are clearly major risk factors for children and adolescents.

This chapter, specifically, will look at the incidence and effects of physical and sexual abuse, the dynamics of abuse, the youthful offender, and strategies for intervention. Intervention strategies will be reviewed for both immediate and delayed timeframes. Three case studies will be presented to illustrate these dynamics and interventions.

Incidence

Physical Abuse

In reviewing incidence studies in physical abuse, Justice and Justice (1976) reported a range of 37 to 63 cases of physical abuse per 100,000 children but cautioned that the number of reported cases was increasing. A later review of estimates noted ranges from 200,000 to 4 million cases per year (Goldstein, Keller, & Erne, 1985). The American Humane Association (AHA) (1981) showed that 750,000 children were *reported* as abused or neglected and that there was an increase of 15.7% over the previous year. The AHA data show that major physical injuries were reported most frequently in young children (less than 3 years old) and older children (12–16 years old), with about equal proportions of male and female victims.

Sexual Abuse

Finkelhor (1984) reviewed incidence studies related to sexual abuse. Incidence rates, rather than actual numbers, are reported with rates ranging from 5% to 9% for boys and 8% to 38% for girls. Finkelhor effectively points out that even if no more than 10% of girls and 2% of boys were abused, clearly a conservative estimate, there would be over 200,000 new cases of sexual abuse each year.

We also know that sexual abuse is primarily committed by men (Finkelhor, 1979; Bell & Weinberg, 1978). Men abuse about 95% of female victims and 80% of male victims. The most common age for victims is 8 through 12, but with many cases outside that range (Finkelhor, 1984). Most female victimization occurs within the family, whereas boys are more likely to be abused outside the family (Finkelhor, 1984).

Conclusions

We are at a point of using a new rule for describing incidence factors for both physical and sexual abuse: Imagine the worst scenario, then accept the reality that it's worse than that. Despite the media hype we frequently see as *over*stating the problem, several factors point toward *under*reporting:

- Much of the work with survivors and victims involves retrospective reporting, discussing past incidents that were never originally reported. This is particularly true in sexual abuse. These reports include relatively recent (10 years) incidents that clearly would have fallen under mandatory reporting.

- Increasingly severe penalties for the offender, particularly for sexual abuse, discourage children from reporting or testifying against a family member.
- We, as adults, are so uncomfortable with the problems that we would rather ignore them and not "get involved."
- The victimization of boys is particularly repressed by our societal sexist beliefs that only girls are victims, only boys are offenders, and boys can't cry, (or tattle or feel or care) and have to learn to "take it."
- We frequently "blame the victim."
- Children are not believed.

I'm often asked if there is a greater incidence of abuse or if it is "just" being reported more. In my clinical experience, the answer is "Yes."

Clearly, we are a society that continues to abuse, exploit, and victimize those that are less powerful. Unfortunately, the consensus is that children are too often the targets. But even when they are the targets, they are not the only ones to feel the impact. Child, family, and society all take the blows and feel the violation.

Effects

Most of us, despite our societal lethargy, are concerned about the children, the victims of physical and sexual abuse. Sometimes, the damage is obvious—the bruises, the scars, the ultimately violated, lifeless body. Most of the time, however, the damage is not so visible. Recent research clearly confirms the effects of abuse. Physical and sexual abuse have been linked, for example, to illicit drug use in adolescents (Dembo, 1987) and multiple personality disorder (Coons, 1986).

Physical Abuse

Physical abuse, specifically, is thought to affect children by creating behavior problems and reduced social competencies (Wolfe & Mosk, 1983); lowered self-esteem, antisocial behavior, and suicidal tendencies (Galambas & Dixon, 1984); acting out, depression, generalized anxiety, extreme adolescent adjustment problems, emotional-thought disturbances, and helplessness-dependency (Farber & Joseph, 1985); fewer friendships and less ambition (Oates, 1985); poor peer relationships, social skills, and empathy (Lamphear, 1985); aggressive tendencies (Graybill, 1985); and delinquency, depression, attachment disorders, and sexual abuse (Steele, 1986). Broader effects on intellectual, cognitive, social, emotional, and linguistic development were noted by Cicchetti and Beeghly (1987) and Cryon (1985). Neurological abnormalities were reported in 53% of a sample of abused children (Martin, Beegley, Conway, & Kempe, 1974). Children have also been observed to develop patterns similar to abusing parents (aggression, isolation, and lack of empathy) as early as at 1–3 years of age (Main & Goldwyn, 1984). Abused children have been noted to have little confidence in their ability to influence or have control over their own experiences (Barahal, Waterman, & Martin, 1981). These data may be among the most critical because they underscore the concept of the physical abuse cycle. Among abusing parents, 30% to 60% say they were abused as children (Justice & Justice, 1976). The exact manner in which this cycle is created certainly varies from one case to another, but clearly the child receives messages that violence is necessary and productive, "might makes right," and that children are powerless possessions of parents. These messages are apparently so strong that they overwhelm the "logic" that those adults who were abused as children should "know better." The ultimate irony is that physical abuse may be the biggest cause *and* effect of physical abuse.

Sexual Abuse

The effects of sexual abuse specifically have been linked to difficulties in healthy sexual functioning and self-esteem (Burgess, Holmstrom, Groth, & Sgroi, 1978); runaway behavior and delinquent/criminal activities (McCormack, 1986); lowered confidence, fewer friends, more aggression, increased sexual awareness, and behavior and academic problems (Tong, 1987); and prostitution (Silbert & Pines, 1983).

The intergenerational effect in sexual abuse is less clear than in physical abuse, primarily because of its currency and lack of longitudinal research. Finkelhor (1984) noted that much of the research that points to an intergenerational cycle has been done on convicted offenders, perhaps not a representative sample. Clinical experience, however, shows that many offenders do not disclose, or even explore, the possibility of victimization until well into the treatment process. This may actually result in an underestimate of the number of offenders who had been abused.

Sexual abuse has one specific but complex effect on many victims—sexualization. Sexualization refers to a developmental anomaly created by inappropriate exposure to sexual contact. Although it could be rooted in unusual exposure to sexually explicit media or adult-adult sexual behavior, it is likely to occur as a result of sexual abuse. This experience results in an artificial acceleration of psychosexual development. For example, the victimized 11-year-old shows the flirting and dating behavior of a 16-year-old while, of course, retaining the cognitive, physical, and social development of an 11-year-old. The sexualized child is clearly at risk for sexual behavior, early pregnancy, and sexually transmitted diseases.

Conclusions

The impact of physical and sexual abuse is not easily quantifiable but is clearly seen in school and clinical settings and supported by the clinical experience of counselors and others. Some effects are:

1. The loss of trust, security, and the essence of childhood;
2. Ambivalence and conflict of feelings—love and hate, rage and guilt, stoicism and fear;
3. The creation of defenses: walls of denial, repression, and dissociation, the armor of anorgasmia, anorexia, and obesity; the weapons of the fist, the tongue, and the belt; the retreat to the bottle, the pill, and depression; escape from the family, society, and reality; and
4. Death, frequently invisible, unnoticed, unmourned, by overt or covert suicide.

The frustration, of course, is that we don't/can't/won't deal with abuse until these time-bomb symptoms explode, and even then we don't link these with abuse unless we ask the right questions of the adolescent or adult sitting in front of us. Like with underreporting, we probably underestimate the damage of abuse to the child and the child within the later adult.

Damage to the family is less often noted. The strained dysfunctional marriage (or adult-adult relationship) is both a cause and effect of abuse, with the reported incident frequently acting as the crisis precipitant of divorce, separation, or abandonment. The nonoffending spouse, if there is one, becomes torn by guilt, fear, and anger, forced into the divided loyalty of spouse and mother, like the TV juggler with the apple, bowling ball, and chain saw. The siblings of the victim (if they are not yet victims themselves) not only are fearful for themselves but also defend against this by blaming the victim, for if the victim "deserved it" or "asked for it," then the offender can still be loved and trusted. Even extended family is drawn into the fray, sometimes as supporters, sometimes as blamers, sometimes reliving their own guilt as past abusers.

The damage to society is detailed throughout the other chapters of this volume, for as abuse affects the child, it becomes a (or the) major contributor to problems of suicide, self-esteem, sexual acting out (and related problems of pregnancy and sexually transmitted diseases), eating disorders, runaway behavior, and so forth. Societal costs are economic (protection, prosecution, punishment), productive (loss of earning potential, long-term costs of disability), and structural as its familial foundation crumbles.

Dynamics

Everybody asks "Why?" The victim, the offender, the family, the teacher, the physician, the judge, the taxpayer, and persons who are going to be abusers themselves for the first time *today*—all ask "Why?" It would be wonderful if abuse could be discussed in terms of a misplaced gene or a hormone run amuck or a mysterious tumor. It can't, and it doesn't go away. The more we explore, the more we find patterns (not profiles), clouds (not clarity), questions (not answers), and rather reasonable-appearing individuals and families (not deranged sociopaths and perverts). There are no definitive answers.

Physical Abuse

We live in a society that not only tolerates but also condones the hitting of children. We teach spanking of children in order to break their will (Dobson, 1970), use corporal punishment in our schools, the societal institution that is supposed to model relationships with children (Maurer, 1972–1978), and generally devalue children and childhood (Elkind, 1987). We are also a society that values violence and advocates violent solutions to problems (*TV Guide*, any week). Obviously, we should not be surprised that physical abuse exists. But we *are* surprised!

Physical abuse may come from either parent and may be directed at one or more children, frequently in a repeated pattern, and is typically accompanied by abusive language and humiliating punishment that may not be physical (Justice & Justice, 1976).

The dynamics of the physically abusive family are reviewed by Justice and Justice (1976), who integrate seven models—psychodynamic, personality or character trait, social learning, family structure, environmental stress, social-psychological, and mental illness—into an eighth model they term "psychosocial systems." This goes beyond the family system to include the components of the other models, from internal to external influences. The abusive family is seen as having difficulty coping with changes and shifts that occur in systems, particularly those labeled as life crises. The family is frequently isolative, with poor support, and enmeshed: that is, fused within itself into a rigid system. Such families are then unable to handle children's behavior problems, particularly in combination with other stresses.

These dynamics produce what Bowen (1966) described as undifferentiated individuals. These undifferentiated adolescents are those that we consider to be at risk and likely to repeat the cycle of abuse, as well as the other behavioral effects noted earlier.

Sexual Abuse

A similar set of dynamics also applies to intrafamilial sexual abuse. These families are seen as isolative, rigid, and conservative/traditional in their style (Finkelhor, 1979; Herman, 1981). They tend to devalue or discount communication and depend on clear power structures. They are not cohesive and adaptable (Alexander & Lupfer, 1987).

There are some patterns, of course, that are specific to sexual abuse and more complex. The research and clinical experience in this area are more recent and hampered by societal bias and language/jargon confusion. Although much of society condones *some* hitting of children, there is universal contempt for *any* sexual contact with children (even sexual abusers detest other sexual abusers). It is interesting that the roots of this contempt may well have more to do with out societal negativity toward sex than with our desire to protect children.

Like other stereotyping processes, language reflects society's negativity. Terms like *molester*, *pervert*, *deviant*, and others even more hostile, prevent us from understanding and solving the sexual abuse problem. I have proposed using the term *pedosexual* to refer to any sexual contact between an adult and a child.

Pedosexual behavior is a heterogeneous grouping with different family and psychodynamic issues. In this chapter, the focus is on intrafamilial sexual abuse because it is the most common form, but the reader should also be aware that youth may also be victims of:

- Pedophilic contact, where the offender has a compulsive arousal pattern to prepubertal children;
- Rape, where physical trauma and violence may inflict additional problems;
- Addictive sexual behavior, where the child may become an "outlet of opportunity"; and
- Extrafamilial contact, where the offender may or may not be previously known to the child.

Intrafamilial sexual abuse may have rather differing systemic patterns. These patterns represent different ways in which the role boundary that divides adults and children in a healthy family is violated. That boundary may be violated by: (1) a dictatorial father, who sees spouse and children, equally, as possessions for his sexual gratification; (2) an immature/dependent/irresponsible father, who becomes like one of the children by exhibiting irresponsible work, relationship, or substance abuse behavior; and (3) a pseudoadult child, who is encouraged to become a substitute mother/spouse.

Societal dynamics are also clearly important in sexual victimization because it is clearly an offense committed by men against (mostly) women. Even when men are victims, there is still the concept of sexual objectification, the use of those less powerful for sexual gratification (Finkelhor, 1984; Russell, 1986).

Conclusions

Both physical and sexual abuse create current and future problems for the child that may be related, in intensity, to the amount of coercion and conflict involved. Finkelhor (1984) emphasized the impact of coercion on the future adjustment of sexual abuse victims, noting that prognosis seemed better, for example, for children who were verbally seduced as compared to those who were physically intimidated or threatened with weapons. The coercion factor applies similarly to physical abuse victims.

What is less clear is the component of emotional conflict. Clinical experience has shown the tremendous energy behind the love-hate dilemma of abuse victims. Children in both physically and sexually abusive families retain affection for each parent even while fear and anger stir beneath the surface. It seems that the greater this love-hate conflict, the more difficulty the child has in resolving abuse issues. This conflict may be felt more often in sexual abuse situations where the behavior may seem less hurtful or painful to the child, also increasing the probability that the child feels guilty about "enjoying" the abuse. In both types of abuse, the child may also feel that he or she "deserved it," again increasing the guilt and confusing responsibility issues.

Why does one family create physical abuse whereas another creates sexual abuse? Or both? The answer is not clear. There is no clear profile for offender, nonoffending spouse, or children in either abuse situation. What does seem to be common between the two are consistent issues of control and power. In either situation, the parents are likely to feel a significant lack of effective power and control. They attempt to gain, or regain, some of that power and control through dominating the children, which results in a transient feeling of power but also feelings of guilt that perpetuate the original feelings of powerlessness and loss of control. On the contrary, but to a lesser extent, the children in both situations may be imbued with a false sense of power that actually increases their vulnerability.

With both power and control as central issues, it may well be that sexual abuse is differentiated by the sexual nature of the behavior. This sexual component may or may not include specific sexual arousal to children, but does include the previously mentioned objectification. This sexual component may be added to the basic power and control issues through previous victimization, societal sex negativity, problems with intimacy or sexual dysfunction, or a combination of conditioning factors.

The Youthful Offender

Another unique component of sexual abuse dynamics is the emergence of the youthful offender. Clearly, this is a topic of interest for those working with at-risk youth. Some offenders are even prepubertal.

The issue of sexualization leads to the discussion of the offender-as-victim-as-offender. Although exact numbers are hard to determine, clearly a majority of youthful offenders have been victims themselves although, perhaps, untreated. Although the effect of sexualization is the biggest factor here, the dynamics of the victim of abuse are similar to those of the offender in this age group—isolation, alienation, and lack of intimacy. The sexualization acts as the magnifying glass, focusing these dynamics into a pedosexual contact.

How does victimization turn into offending? Certain clinical observations may provide helpful information. The pedosexual behavior is likely to be limited to genital touching, although there may be other sexual behaviors such as exhibitionism or voyeurism. The victim is likely to be prepubertal and known to the offender, whether intra- or extrafamilial. The young offender is likely to have a history of physical or emotional abuse in addition to sexual victimization. This may reflect a generally chaotic family structure, sometimes held together by rigid rules and expectations. The offender may be rather compliant, withdrawn, and isolated from peers. Asocial behavior is more likely than antisocial behavior. There may well be gender identity or sexual preference confusion. There may also be a generalized preference for nonsexual contact with younger children.

We are struck by a picture of low self-esteem and inadequacy in the young offender, particularly in dealing with peers. There is also a probability of school adjustment difficulties. Obviously, if there has been sexual victimization, most of these noted patterns could be exaggerated.

The youthful offender clearly has unique concerns. Much more clinical experience and research are needed in order to address these concerns.

Interventions for Physical and Sexual Abuse

Typical intervention approaches in the physical and sexual abuse arenas have been family-based. This is particularly true as counselors work with at-risk youth. The specific intervention strategy is, of course, going to depend on the situation. Counselors know, however, that family dynamics issues, whether past, present, or future, will have a big impact on their work. Regardless of the specific strategy—individual, family, or group; therapeutic or educational—family issues need to be addressed.

Intervention strategies involving the victim of physical or sexual abuse are similar enough to be grouped together in a chronological sequence for this discussion. Exceptions will be noted. Within this broad strategic approach, many specific techniques may be utilized, and counselors may well find themselves utilizing several different techniques, approaches, and modalities on any given case.

Therapeutic models include play therapy (Long, 1986; Oaklander, 1978; Sgroi, 1982); mother-child bonding (Damon & Waterman, 1986; Giaretto, 1982); family systems therapy (Friedman, 1988; Giaretto, 1982; Gelinas, 1988); group therapy (Porter, Blick, & Sgroi, 1982; Blick & Porter, 1982; Delson & Clark, 1981; Justice & Justice, 1976), and others. Educational models were reviewed by Goldstein et al. (1985) to include control and interpersonal skills and improved parenting. The strategy described will include components of all those approaches.

In order to be implemented effectively, any of these approaches should include some clear, underlying philosophical assumptions. These assumptions are necessary because both physical and sexual abuse test the limits of our ability to be objective, empathetic, and nonjudgmental.

These assumptions include:

1. The problem is treatable. The victim becomes the survivor.
2. The victim carries *no* responsibility for the abuse but can assume responsibility for recovery.
3. Acceptance of feelings and provision of support are consistently necessary.

Immediate Intervention Strategies

Intervention strategies are either immediate or delayed, the latter occurring 1 year or more after the last abusive contact. Clearly, individual case situations determine specific strategies, but experience has shown the need for different approaches for these timeframes. Counselors may, of course, become part of (or withdraw from) the intervention process at various points.

The counselor may be one of the first adults to hear of abuse. This awareness may be direct (observation of, or verbal report from, the child) or indirect (another child, a friend's parent, teacher, or school nurse). The task of the counselor remains the same: Report the abuse and support the victim.

The report must not only be made because of legal mandates but also because the protection of the child has to be the highest priority. The child should be told that a report will be made. The report, in fact, validates the child's self-worth and right to protection.

During the session when the child initially discusses the abuse, support takes precedence over interrogation. The tendency to press for details may be neither helpful nor necessary. The counselor should avoid "playing police" and focus, instead, on reassuring the child of having done the right thing and accepting the child's feelings of fear, anger, guilt, ambivalence, and confusion.

Although counselors can have a positive impact during this crisis intervention phase, the *primary* focus has to be on protection of the child. This is *not* the counselor's role, rather that of the Child Protective Services or law enforcement. The counselor can assist the protection process, however, by providing accurate information about the child and supporting the child through the often confusing maze of "the system."

"The system" includes law enforcement agencies, child protection departments, attorneys, courts, and probation officers—any one of which could be intimidating to children. The counselor, acting either as primary therapist or supportive counselor, can play a critical role in providing assurance to the child that any feelings will be accepted. This should be done without unduly predictive statements from the counselor like "Everything will be better," or "Don't worry, he'll be going to jail," or "You'll be going home soon," which may not turn out to be accurate.

Although specific feelings may be somewhat different in physical versus sexual abuse situations, there may be even more variation from one individual to another. Whereas physical abuse may primarily trigger fear and anger/rage reactions, sexual abuse also includes an increased probability of guilt. The sexual abuse victim seems to have wider swings from fear to rage to guilt. The latter is the most difficult for many adults to understand. The affectional bond between parent and child remains more intact than we anticipate, compounded by the child's natural egocentricity, which results in the perception that the cause of the family's problems is the report rather than the abuse.

The guilt a victim experiences is so strong that the counselor should assume that there is a suicide risk in every case and monitor that possibility during crisis times. The critical phrase here sounds something like, "They'd be better off without me," or "I'm the cause of all the family's problems." The suicide risk is particularly high in adolescents, but all members of the family should be considered to be at risk.

The key to dealing with this fear, rage, and guilt, particularly during the crisis stage, is a focus on "the child." These feelings are *all* "OK for kids" and *totally* acceptable. The children can have an appropriate sense of relative powerlessness in order to emphasize their lack of blame, fault, and so forth. They can retain this developmental role of child and still build appropriate power. At this point, the "permission" to feel is critical.

The counselor can be an advocate for, and supporter of, the child without "offender-bashing." Counselors risk involving their own biases of anger and disgust toward the child abuser, which only adds to the child's confusion. Instead of being in an adversary relationship with the offender(s) and the rest of the family, the counselor can begin the process of systemic intervention here in the crisis phase. The counselor can provide (or coordinate with other involved counselors/therapists) support to other family members: encouraging the treatment process, providing a safe venting space, providing information when possible, and making referrals. It may not always be possible to make this systemic intervention (e.g., if the parents deny the abuse). If such is the case, the child will clearly need the primary support of the counselor.

Clarification of roles and responsibilities. The second stage of intervention requires more emphasis on the family system. The systems approach acknowledges that the whole family, with all its internal and external influences, has set up the structure and dysfunction that led to the abuse, either physical or sexual. The systemic framework can be helpful even if the counselor has access only to the child.

As noted previously, the issues of dysfunctional role boundaries, inappropriate division of power, and gender role stereotypes are all a part of the destructive family system. Because the whole family has been involved in setting up these patterns, it's not surprising that statements arise like: "Mom pushed him to do it with her nagging," or "Rickie deserved to be hit," or "Susie liked the attention," or, the classic rationalization, "Everybody knew about it but nobody did anything." These statements are frequently used not only by the offender, but also by the whole family. So who's really the "bad guy"?

It may be helpful to look at the tricky concept of dual responsibility. First and foremost, the abuser is *one hundred percent* responsible for the choice to give up control and cross the line of appropriateness regardless of the actions or reactions of the child. This is essential to emphasize—100%.

There is, however, a separate and distinct responsibility the whole family has for having established the patterns and atmosphere that existed at the time of the abuse. The adults (parents) have a major share of that responsibility—the marriage relationship, parenting behaviors, financial and household management. All the children, to a lesser degree, also have their share of responsibility for family functioning. This notion of family/system/corporate responsibility enables the counselor to enlist the whole family in mutual empowerment and responsibility for changing the maladaptive behavior, a very powerful, positive force.

Accepting this responsibility is difficult for many families and resistance to treatment is typical in this phase. This is voiced as, "Let's forget the whole thing and put it behind us." Even the victim is likely to cooperate with this resistance which, if allowed, would plunge the family back into their old dysfunctional patterns.

The major goal of this treatment phase is to return the child to the appropriate child role in the family by expressing feelings, receiving nurturance and protection, and taking an age-appropriate share of responsibility. One of the most powerful tools for accomplishing this is through the apology/confrontation sessions, also perhaps the most challenging sessions for the counselor.

The apology sessions are a series of structured confrontations between the victim and abuser and may also include the nonabusing spouse and others in the family. Sessions are similar whether or not the family is together or whether it even will be reunifying. The first of these sessions should take place as soon as the child is ready, and the bulk of them may occur during the middle stages of treatment.

The child must have a good sense of being protected before attempting a direct or indirect confrontation. This includes having discussed details of the abuse with his or her counselor and having acknowledged (probably not yet resolved) the feelings. The child should have a sense of having a support system whether or not he or she really "wants" the confrontation. Both child and abuser should be specifically prepared for the session by role-play or similar techniques.

The initial apology session should include the child, the abuser, the spouse, child's counselor, and abuser's counselor (if different). The child can be shown the room and introduced to the abuser's counselor if either are not previously known, and the child can set the seating arrangement for comfort. If the child and the abuser have been physically separated for some time, the initial contact may be anything from a "cold" stare to a cheerful hug. The abuser will be encouraged to apologize for the specific behavior of the abuse as well as its "set-up." Responsibility issues will be clarified, and the report to authorities will be acknowledged as a positive and necessary action. The child's responses, although frequently not predictable, will nevertheless be reassured as "OK." Further apology sessions will focus more on details of the abuse, patterns that set it up (including substance abuse and communication issues), and the "family secret" dynamics.

There are many cases, of course, where this direct confrontation is not possible. The same basic goals apply in an indirect confrontation: expressing feelings, clarifying responsibilities, and creating protection. Strategies include role-play (with counselor, with dolls, other counselors in the support team), Gestalt techniques (empty chair, pillow, doll burial symbolism), writing or dictating letters (or drawing pictures), which may or may not be sent to the abuser, or other expressive play (clay, paints, etc.). These confrontations, even if indirect, should still be structured, with clear closure points.

Empowerment. The third focus of treatment is empowerment. This focus is not necessarily time-defined but is, rather, a sequence of tasks that proceeds through the whole treatment process. The basic sequence of empowerment used by this author is:

1. Reinforcement of the report;
2. Rebonding with the nonabusing parent;
3. Assertiveness and self-protection;
4. Redefining the relationship with the abuser;
5. Resumption of age-appropriate roles whenever possible; and
6. Positive control and attitudes regarding violence (physical abuse) or sexuality (sexual abuse).

The imbalance of power is one of the key elements in setting up both physical and sexual abuse. The child is powerless against the physical, verbal, and affectional power tools of the adult. Children may show this powerlessness in seemingly contradictory behaviors—one child becoming withdrawn, isolated, and helpless; another acting out sexually or aggressively and rebelling at school.

Regardless of the behavior, the roots are the same—powerlessness and anxiety. These effects may be doubly traumatic when one considers that in many families these children are given unusually powerful, responsible, pseudoadult roles before the abuse.

After the abuse, the child may use inappropriate power techniques to regain the perceived loss of power. Parents can try to deal with this through typical techniques such as limit-setting and explaining consequences. They also, however, can use positive approaches to *empower* the child, reducing the child's need for unproductive power. The first time for emphasizing this positive power is at the time of the report.

The report can, of course, be a scary time because it is a powerful "weapon" for protection. The child needs strong reinforcement that the report is a reasonable and appropriate process, and that now adults will be responsible for his or her protection.

The nonabusing spouse will, it is hoped, be the most important "protector" of the child, therefore, this relationship needs a special focus in order to accomplish "rebonding." This dyad should receive special focus in treatment and visitation, continuing to meet as a dyad at various times throughout the treatment process.

One of the most difficult goals of empowerment is obtaining a balance between assertiveness and self-protection on one hand and aggressiveness and dictatorial power on the other. The child does have the capability for self-protection and the right to privacy of his or her body, including the right to "say no" while maintaining the child role in the family. The basic message is similar to what we would give to an adult—"Taking care of myself does not infringe on the rights of others or relieve me of social or familial responsibilities." This focus on assertiveness is facilitated greatly through peer group work.

It seems obvious that the child's relationship with the offender must be redefined. A great deal of society would redefine the relationship by separating the two—by either incarcerating the offender or removing the child. There are other options. Through the combination of individual, dyad, triad, and group treatment as well as carefully monitored visitation, a major shift can occur in that relationship.

One frequent question professionals and others ask is how the victim (or any of those involved) can possibly "forgive and forget." The truth is that they don't. And they probably shouldn't. One analogy that may be helpful is that the abuse, like other traumatic events, is eventually "filed away"; that is, abusive incidents certainly continue to exist as memories but, with time, are removed from daily routines. There may be times, of course, when the files are pulled back out so that some issues can be handled. This "filing" analogy allows victims and families to get on with their lives while still acknowledging the reality and responsibility involved, rather than using denial and minimization that exemplify the pathology.

The last focus in the empowerment process is a reinforcement of positive control. For the physically abused child, this includes information and modeling that demonstrate that problems can be resolved without violent physical means. For the sexually abused child, there is also the need for correct and *complete* information about sexuality (despite possible parental resistance), including anatomy and physiology, sexual response, contraception, values, psychosexual development, relationships, and societal attitudes. The child also should receive strong messages about (1) the need for consensuality and lack of harm, in contrast to his or her own experiences, and (2) the concept that being in positive control over self also includes a positive control over his or her sexuality. Empowerment, then, includes the concepts of positive, assertive control and responsibility, as well as appropriate feelings of power.

Group methods. The use of group work can be an important part of a planned intervention, as well as a prevention mechanism. Groups may be focused on self-help and mutual support, education, counseling/therapy, or a combination thereof. They may be oriented toward children (victims or siblings), parents, or whole families. Structured self-help groups such as Parents Anonymous for physical abuse and Parents United for sexual abuse provide national networks for support and education and may be a helpful resource.

Parent groups were described by Otto (1984) and Devoss and Newlon (1986). Damon and Waterman (1986) provided a highly structured parallel play group model in which mothers and children meet separately and together with an emphasis on bonding/rebonding.

Delayed Intervention Strategies

The counselor working with at-risk youth, whether in the school, mental health program, or other settings, typically has the benefit of dealing with the abused child within a year of the last abusive incident. Because many children are abused in their preadolescent years and the abuse is not reported, there are situations in which the counselor may be dealing with a delayed intervention even though the client is still only an adolescent. The strategies for delayed intervention are similar whether the client is male or female, adult or adolescent, with some individual variations.

The overriding issue in delayed intervention is that, to a greater or lesser degree, the child has built up defenses to cope with the abuse. Although these defenses may initially have been functional, they will probably present significant obstacles to both identification and treatment of affective, relationship, and sexual issues.

The first obstacle is the presenting problem. With delayed intervention, the presenting problem seldom *seems* to be related to the abuse. Typical issues for adolescents include peer fighting, running away, sexual behavior, substance abuse, or withdrawal. These issues, of course, are also typical for nonabused adolescents. Do we assume that all children have been abused? Not exactly—but close!

For abused children, a general question about family functioning such as "How are things going at home?" may trigger anxiety and secretiveness. Even if this kind of question doesn't elicit strong reactions, the counselor can use general permission-giving statements such as "Lots of times kids tell me about scary (painful/unusual/inappropriate) things that have happened to them. Sometimes things have even happened a long time ago." A follow-up permission statement may be something like, "Sometimes parents hit kids (pause) or yell at them a lot (pause) or touch them where it doesn't feel good (pause). Kids talk to me about that kind of stuff." The permission statements should remain that and not turn into interrogation. Permission may act like a seed that bears the fruit of a later report.

In the delayed intervention, counselors often ask whether they are still mandated to report the abuse to authorities. Because there are generally no specific time exemptions in reporting laws, the general answer is still to report the abuse even if CPS or law enforcement chooses not to take action. They may make their decisions based on the need to protect the identity of the abuser, type of abuse, and so forth, but this is not really the counselor's decision. If the victim/survivor is over 18 at the time of the report, mandatory reporting would not typically apply, but the counselor may still have an ethical obligation to report if other children are, or may be, at risk.

Clarification of issues and empowerment. If the victim/survivor acknowledges a history of abuse, the counselor may still have to exercise patience in allowing details to surface through consistent permission and encouragement, again without interrogation—"You've told me about your father touching your breast. Sometimes remembering that gets you thinking about other things that may have happened."

Because of the strong defenses seen in delayed intervention, there is frequently a strong emotional conflict that has been repressed. As noted earlier, this conflict (affection vs. rage, love vs. hate, pleasure vs. disgust, guilt vs. anger, fear vs. intimacy) is a major treatment issue and should receive extra attention from the counselor. The client may be resistant to exploring this conflict.

That same repression and resistance may also apply to feelings in general. Affective awareness may be an important goal, especially if there is indication of dissociative behavior. Clients may report an inability to feel pleasure or anger. One of the tragic ironies in these cases, for example, is the young woman who engages in sexual behavior often but is not orgasmic. Counselors may find themselves spending considerable time and effort exploring feelings that may or may not seem relevant to the abuse.

Clients, particularly adolescents, may express strong reservations regarding the possibility of reconciliation or reunification. They can be reassured regarding their safety and need for protection. They can also be encouraged to use the counseling process for their own psychological confrontation and reconciliation (see previous section on the apology process). They can be given the option of bringing out the unresolved issues, dealing with them, and then "filing them away," all with the emphasis that they have control over the process and, in fact, their life.

Group methods. One final strategy in delayed intervention is the use of group structures, both support groups and therapy groups. Although groups may generally be valuable treatment modalities for both victims and abusers, they are particularly valuable in delayed intervention. Mutual support, especially during psychological confrontation, is critical, as is reinforcement for affective awareness and empowerment. Self-help groups such as Parents Anonymous and Parents United may again be helpful here.

Case Studies

Three case studies will be presented to illustrate typical cases, treatment strategies, and outcomes. Abuse cases, of course, are heterogeneous and demand individualized planning. These cases illustrate that variety and some similarities. They are actual cases with slight changes for confidentiality, without exaggeration.

Case 1—Maria

Maria is a 6-year-old girl, an only child, who came to school with a handprint on her left cheek which, she said, came from her mother's slapping her at breakfast. The school nurse reported to Child Protective Services while the counselor reassured Maria and stayed with her during the CPS investigation. Because the CPS files included multiple abuse, Maria was transported to a hospital for evaluation and then to a temporary shelter facility. Medical evaluation revealed a previously broken wrist. Parents acknowledged the reported incident but denied chronic abuse and were extremely angry at the school and CPS. Follow-up police/CPS investigation alleged that both parents were physically abusive and that the mother had a history of alcohol and cocaine abuse. They were not arrested. Maria was declared a dependent of the state by juvenile court and placed in foster care, and the parents were mandated into treatment.

The initial treatment plan included individual (play) therapy for Maria, conjoint counseling for the parents, substance abuse monitoring for the mother, and participation in Parents Anonymous. Early treatment reports on Maria indicated that she was withdrawn, anxious, and unwilling to talk about the abuse. Doll and puppet play was family-oriented and paintings were mostly rainbows, flowers, and suns. Parents continued to deny the chronic abuse for 3 months after the report and then, over a 4-week period, unfolded the history of abuse during counseling and Parents Anonymous sessions, discovering that they each knew only about half the abuse that the other had committed. Supervised visitation began after they acknowledged responsibility.

The treatment plan was modified to include individual therapy for each parent. An initial apology session was held, with the parents tearfully acknowledging responsibility for the abuse. Maria, on the other hand, showed little emotion during the apology session, although she seemed to understand and accept the parents' apology. It was also reported that Maria was stealing food and small amounts of money in the foster home. Maria didn't respond verbally to these allegations to the foster parents or in play therapy. She did, however, engage in abusive puppet play and drew colorful but heavy-pressured designs. The therapist treated both the behavioral and symbolic indicators of anxiety by encouraging the expression of feelings and reframing choices in many areas of Maria's life.

Six months after the report, Maria was less anxious in therapy, with improved adjustment noted in school and the foster home. Two more apology sessions had focused on Maria's adjustment and the parents' responsibility. The treatment plan was shifted toward dyad (marital) and triad sessions focusing on roles and responsibilities. Visitation was expanded to include unsupervised visits with the parents.

Nine months after the report, the family was reunified, although the dependency status was maintained for another 6 months, with continued periodic counseling. The parents chose to maintain participation in Parents Anonymous.

Five years later, mother initiated counseling for herself subsequent to divorce. She had remained drug-free and sober and reported no further abuse incidents. Maria was functioning very well. Mother had given birth to a boy, now 3 years old. The parents were given joint custody. This reinitiation of counseling successfully dealt with mother's concerns about her coping skills, issues regarding relationships, and career planning.

Case 2—Jason

Jason is a 9-year-old boy who was voluntarily turned over to Child Protective Services by his father and stepmother on grounds that he was dangerous to his younger sisters (ages 5 and 2) because of physical attacks, one alleged attempt at setting fire to the 5-year-old's bed, and fondling and oral sex with both younger sisters. They had previously relinquished custody of Jason's 11-year-old sister after she had apparently initiated sexual contact with him, the 5-year-old, and at least two children in a day-care center. The father and stepmother had reluctantly assumed custody of the three oldest children about 18 months ago, after the children were removed from the mother's custody in another state. In that investigation it was alleged that mother performed mutual oral and manual sex with Jason and his older sister and forced these two children to perform oral sex and coitus with each other in front of a group of adults. She would severely spank Jason (more intensely than the others) and afterwards "make up" for the spanking by fellating him. Mother was charged with sexual abuse but fled the state to avoid prosecution. The father and stepmother acknowledged increasingly severe physical punishment of Jason but denied sexual abuse (this was corroborated by the children). They refused participation in treatment and eventually permanently relinquished custody of all three oldest children to the state.

Jason was placed in foster care and individual therapy was initiated. He was in five foster placements in 4 months because of his behavior, including fondling younger children, urinating and defecating in corners, and stealing. Individual therapy included attempts at appropriate expression of feelings (verbally, and through art and play), trust-building, and limit-setting. The individual therapist also provided supportive counseling to the foster parents. Jason was also placed in a self-contained class for the emotionally handicapped.

A stable foster placement was arranged after 4 months and continued for 2 years, at which point the (natural) parental rights were severed and the foster parents adopted Jason. During this 2-year period, individual therapy continued with the same treatment goals, expanded by a focus on the sexual issues, anxiety/rejection concerns, clarification of roles, and self-esteem improvement. Foster parents were seen regularly. The sexual and aggressive behaviors continued for about a year but decreased in frequency. During this time, there was an increase in telling of lies, mostly denial of wrongdoing. There was at least a monthly coordination among the therapist, foster parents, CPS case manager, and school personnel.

By the time of the adoption, Jason's behavior had stabilized. For a 6-month period, there had been no sexual behaviors, with problems limited to stealing and lies.

Treatment continued for almost 1 year after the adoption (total of almost 3 years since referral), with alternating individual and family sessions focusing on communication, self-esteem, and behavioral issues. Jason continued in his special education placement. The case was closed by Child Protective Services.

Case 3—Kathy

Kathy is a 16-year-old girl who was referred by juvenile court. She had been arrested for prostitution and possession of marijuana and cocaine. Court investigation revealed that she had been engaging in street prostitution for almost 2 years and had been using marijuana, cocaine, and alcohol for at least 3 years. She had been in counseling regarding her substance use/abuse. Physical or sexual abuse was suspected but Kathy denied it. Her family had moved since she had run away and could not be located by authorities. She was in detention at the beginning of treatment.

Kathy was initially resistant to treatment, denying problems and minimizing both her substance use and negative effects of the prostitution. She stated that she was living independently and adequately and didn't want counseling or other intervention. She was offered the option of a female therapist but said she felt more comfortable with a male therapist. To circumvent her resistance, she was given the opportunity to choose the topics for counseling. She initially vented anger at "the system" and then at her "boyfriend," who apparently had "dumped" her.

In the twelfth session, Kathy acknowledged more general problems in relationships with men/boys. She said she wanted a deeper relationship with one man despite the attention and physical pleasure she received from the serial sexual contacts. She tearfully acknowledged, however, that she had not been orgasmic. This, in turn, led to her revelation that she had been sexually abused by her stepfather from age 9 to 13, on a consistent (weekly) basis including coitus (for the latter 2 years), fellatio, cunnilingus, and mutual digital-anal penetration. She reported significant guilt over both the behavior and the report because she remembered enjoying, and even initiating, the sexual contact. The reassurance process was started at this session and continued for several sessions, focusing on the stepfather's responsibility.

After informing Kathy, a report was made to Child Protective Services, although no formal investigation was made because of the inability to locate the stepfather. Ninety days after her arrest, Kathy was released from detention and placed on probation and into a group home. She was also ordered into outpatient substance abuse treatment and monitoring.

During the 10 subsequent sessions, Kathy was increasingly able to discuss her anger and rage, as well as the guilt involved. She also reported difficulty in peer relations in the group home, with verbal and physical fighting and reluctance to follow group rules. She remained "clean and sober" and continued to deny substance abuse.

Approximately 6 months into treatment, Kathy was arrested for possession of marijuana after running away from the group home. She was detained for 48 hours and then placed into another group home. She reported little remorse for this behavior but agreed to refrain from substance use during treatment. Emphasis was placed on her own responsibility to control her life regardless of the abuse history. She seemed to develop a good therapeutic rapport and was able to discuss various problems relating to her, and her family's, history.

Eight months into treatment, after being restricted by the group home parents, Kathy ran away. Two years later, there was no indication of her whereabouts or condition.

The Challenge

The author hopes that this chapter has clarified the difficulty of dealing with physical and sexual abuse. Whether the intervention is immediate or delayed, abuse issues are complex, heterogeneous, and volatile. They require unusual sensitivity, flexibility, and objectivity on the part of the counselor, whether in the role of primary or supportive therapist.

The counselor may fill several, sometimes overlapping roles in dealing with abuse: primary therapist, support team member, advocate, or prevention and education specialist. All are valuable. The primary therapist typically provides individual counseling/therapy to either victim or abuser and will also be a part of the dyad/triad/family/group processes.

The supportive counselor provides ongoing encouragement and in some cases, practical support for the victim and family. This counselor may be in the school, Child Protective Services, family support/welfare office, or career planning service. The support team, with these members, the primary therapists, Child Protective Services, adult or juvenile probation, and medical providers may make (or provide input into) decisions regarding visitation, treatment planning, or reunification. As a part of this support team, or within the legal/child protective/criminal justice system, the counselor may become an advocate for the child. Advocacy may be necessary to ensure protection, obtain services, and provide for the child's best adjustment.

The school or mental health counselor may also provide, or consult regarding, prevention and education. This may include specific abuse issues (body privacy, protection, etc.) or more general topics (self-esteem, communication, sex education, assertiveness, gender/family roles).

The counselor also needs to be able to deal with a team approach, with its attendant frustrations and logistical difficulties, especially because some individuals and agencies (CPS, law enforcement, etc.) may not be therapeutically oriented.

The counselor should be particularly cautious about recognizing his or her limitations in this area. Even the experienced specialist in the field will frequently refer individuals or families in order to maximize the therapeutic relationship and goals.

The effects of physical and sexual abuse are so pervasive that their presence should be assumed in the majority of adolescent problems until they are definitely ruled out. This can be done routinely, without negative impact on the counseling relationship.

Despite the difficulties, dealing with the abused (and the abuser) presents an important and potentially rewarding challenge. Changes are frequently dramatic and lasting, with many families not only improving from their earlier dysfunction but also actually becoming healthier than "average" untreated families.

If there is one arena where all treatment is truly prevention, it is physical and sexual abuse. Counselors, I believe, have the unique combination of philosophical base and clinical skill to make a major impact on this problem. But first, we have to open our eyes, ears, and hearts!

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Chapter 5

"WHO CARES WHAT I THINK?": PROBLEMS OF LOW SELF-ESTEEM

Sandra S. Meggert

Low Self-Esteem and At-Risk Youth

Joan is 15 years old, is experimenting with drugs and alcohol, is failing most of her classes in high school, seems anxious and depressed, and is threatening to drop out of school. Her parents have talked to the counselor, teachers, and the principal. In turn, each has talked with Joan, but no one seems to be able to persuade her to change her behaviors.

Andy, 16, is withdrawn, has no friends, is not doing well in school, often refuses to attend school, won't talk with his parents or the counselor about himself, and when anyone tries to penetrate his isolation he responds with, "I don't care," or "Leave me alone."

We observe many adolescents in pain. We see many with negative attitudes or low self-esteem and suspect there are many more. Many researchers believe that one of the major causes of deviant or potentially destructive behavior is low self-esteem (Kaplan, 1975; Leung & Drasgow, 1986; Yanish & Battle, 1985). A review of the literature supports the belief that negative self-esteem affects behavior in negative or destructive ways (Aronson & Mettee, 1968; Graf, 1971; Kaplan, 1975; Kaplan, Martin, & Johnson, 1986; Lorr & Wunderlich, 1986; Yanish & Battle, 1985). Kaplan (1976) stated that poor self-esteem or "negative self-attitudes increase the probability of later adoption of each of a range of different types of deviant responses" (p.788).

Low self-esteem is a critical factor in at-risk behavior. Eskilson, Wiley, Meuhlbauer, and Dodder (1986) reported that adolescents who feel excessive demands to succeed academically are apt to disclose involvement in deviant activities, to have low self-esteem, and to feel inadequate and unable to fulfill their families' aspirations for them. Aronson and Mettee (1968) used college students as subjects in a study of dishonesty. They hypothesized that students with "low self-esteem are more likely to engage in immoral behavior" (p. 74). Results showed that 87% of the subjects with induced low self-esteem cheated on a test as compared to 60% of the neutral group and 40% of the induced high self-esteem group. In a similar study, Graf (1971) reported that 40% of those with induced low self-esteem, 17% of the neutral group, and 14% of the group with induced high self-esteem engaged in dishonest behavior.

Kaplan's (1976) theory suggests that low self-esteem influences a person to adopt delinquent or other behaviors that are deviant from the norm. The theory identifies two routes that negative self-attitudes may take to influence deviant behavior. One is that these attitudes make conformity to membership group patterns painful or distressing; the other is "by influencing the person's need to seek alternatives to the disvalued normative patterns in order to satisfy the self-esteem motive" (p.788).

The results of a study of adolescents at risk for compulsive overeating (Marston, Jacobs, Singer, Widaman, & Little, 1988) showed that students designated at risk perceived their life quality as poor, and the authors hypothesized that this meant they are getting along poorly with the person to whom they feel closest. Because self-esteem is closely tied to perceived evaluations from significant others, the quality of significant relationships is a crucial ingredient of self-esteem. The research findings of Yanish and Battle (1985) support the importance of significant others to the adolescent. They found depression in adolescents to be more strongly affected by the relationship with parents than with peers. A longitudinal study by Cohen, Burt, and Bjorck (1987) indicated that low self-esteem and depression, an indicator of low self-esteem, are positive predictors of controllable negative events, for example, expulsion from school.

Simmons, Burgeson, Carlton-Ford, and Blyth (1987) stated that young people who encounter several important life events at the same time they are adjusting to the changes of adolescence are expected to be at greater risk than those who have longer periods of time to adjust to adolescence. Findings in this study show that girls suffer loss of self-esteem, and both boys and girls show declines in GPA and participation in extracurricular activities. For girls, each subsequent life change brings more difficulty with coping. The authors suggest that, in terms of self-esteem, this group of young adolescents would do better if one aspect of their life were comfortable. If this were accomplished, then the timing and pacing of major changes would be of primary importance.

As discussed in the many preceding examples, adolescents who exhibit signs of low self-esteem may be considered at risk for adopting or experimenting with deviant or potentially destructive behaviors. These young people may or may not be responding to life situations with deviant behaviors currently; however, when the signs indicate low self-esteem, interventions designed to improve self-esteem are important to help them avoid at-risk behaviors.

The purpose of this chapter is to examine low self-esteem as one of the primary causes of the at-risk behaviors described above, and provide a framework and strategies to help create positive levels of self-esteem. This is accomplished by defining self-esteem in relation to at-risk youth. Immediately following the definition are some behavioral descriptions frequently linked to low self-esteem, some factors that influence the development of self-esteem, and four phases of interventions with low self-esteem populations, specifically students. Examples of intervention strategies for each phase are included. A case study demonstrates the phases of intervention, and additional successful programs are identified.

Definitions of Self-Esteem

Self-esteem refers to subjective evaluation of worth. These value judgments develop through personal success or failure experiences, interactions with others, maturation, heredity, and social learning, and are formulated from an individual's perspective. Kaplan (1975) discussed the self-esteem motive as being an individual's need to optimize positive feelings about self while reducing negative feelings. It is the process of increasing feelings of self-respect, approval, worth, and esteem. When the balance is on the negative side, a person is said to feel self-rejection, self-derogation, and, in many cases, self-hate.

Self-esteem is also a function of perceived evaluation by significant others. Mack and Ablon (1983) believe that no human is ever totally independent of the evaluation of others, and everyone retains "to some degree, a dependence upon connectedness with others for validation of our worth" (p. 10). A person's self-evaluation is referred to as self-esteem (Robinson-Awana, Kehle, & Jenson, 1986). It is influenced by the individual's feelings of competence and efficacy. Two other terms are sometimes used interchangeably with self-esteem, *self-concept* and *self-acceptance*.

Self-concept refers to the perception individuals have about their personal attributes and the roles they fulfill. Some of these perceptions are accurate, and some are not. We receive feedback about the roles we play and internalize information about the character and quality of our role performance (Beane & Lipka, 1980). "Self-concept refers to descriptive perceptions of self while self-esteem refers to the valuative assessment of those descriptions" (p. 3). For example, individuals have an academic self-concept, a social self-concept, or a physical appearance self-concept. Elliott (1988) maintained that anyone with low self-esteem has an unstable self-concept. The term *self-acceptance* pertains to the degree to which people are comfortable with their self-concept (Frey & Carlock, 1984).

For purposes of this discussion, self-esteem is defined as the pattern of beliefs an individual has about self-worth. It is the subjective part of self-concept, the evaluation of self, and behaviors based on an individual's perceptions of personal experiences and feedback from significant others. It is expressed in feelings of power or helplessness, called efficacy, or in beliefs about personal control.

Indicators of Low Self-Esteem

Beliefs about self develop as a result of perceptions and evaluations of success and failure experiences. In this process, an individual forms some beliefs about personal control (internal vs. external) and personal effectiveness (self-efficacy).

Locus of control refers to a person's belief about outcomes. Locus of control is the conviction that (a) success or failure at a task is internally determined by one's own actions or ability, or (b) the outcome is due to external influences such as luck, fate, or chance. According to Johnson (1981), "internal attributions for success are associated with higher levels of self-esteem" and low self-concept "was predicted independently and significantly by internal attribution for failure and external attribution for success" (p. 174). Abramson, Seligman, & Teasdale (1978) suggested that low-achieving students ascribe any failures to internal causes and all successes to external causes.

Personal effectiveness, or self-efficacy, as defined by Benoit and Mitchell (1987), has four essential elements: *awareness* of required behavior to bring about success, *expectation* that this behavior will be successful, *belief* that there is a relationship between behavior and outcome and that this behavior will have an impact, and that the outcome provides something *valued*.

Evidence supports the fact that an individual with low self-esteem would most likely believe in luck (external control) rather than ability (internal control) to achieve success. On the other hand, failure is attributed to personal shortcomings (internal control). Because self-esteem judges whether an individual can, in fact, succeed at a given task, the lack of belief in self makes it likely that someone with low self-esteem will also exhibit feelings of helplessness or powerlessness, in other words, low levels of self-efficacy. In this case, a possible defense might be to deny that the outcome of the behavior has any value, to withdraw, or to drop out.

Individuals with low self-esteem often find it necessary to develop defenses. People who have low self-esteem hurt. To avoid this hurt there is a tendency to shun experiences such people believe will bring additional pain or to change these experiences in some way. They erect barriers or defenses. At times the individual might be hostile, critical or suspicious of others, or lack identification with others. Sometimes retreating defenses are exhibited when a person avoids coming to grips with problems or denies reality (Kaplan, 1975). A person might retreat into an "I don't care" stance or simply resist trying. It is too much of a risk for someone with feelings of poor self-worth to be exposed to additional hurt or situations where failure is expected.

Persons with low self-esteem may be distractible, timid, shy, withdrawn, inhibited, anxious, less academically able (Domino & Blumberg, 1987), and have a narrow range of interests. They are more likely to daydream and to want to find jobs where they have little or no supervision and where there are minimal amounts of competition. From their perspectives, an ideal situation is where they will have no supervision because then no one can confirm their failure. Generally, they express the idea that they do not really want to get ahead in life. This could be because they will not place themselves in a position where they expect to fail. This too is a defense.

Individuals with low self-esteem have few coping strategies. They often feel a lack of control over life events. They don't feel connected or have few, if any, expectations of future success. They lack a sense of belonging. Possibly, dropping out is a defensive way of demonstrating some power, self-defeating though it may be.

Low self-esteem can cause emotional distress as well. Many individuals who question their worth are sad, lethargic, tense, anxious, and angry. Some of these feelings stem from concurrent feelings of helplessness and powerlessness. Physically they may exhibit sleeplessness, headaches, or nightmares.

Those with low self-esteem are generally dissatisfied with themselves and their lives, are contemptuous of self, and have low levels of self-respect. Typically, they are fearful of new experiences, have a poor physical appearance, and a low energy level. Apologizing, criticizing others, showing an interest in material things, and bragging are all indicators of low self-esteem.

There are parental, social, psychological, physical, environmental, and cultural influences on self-esteem. Several of these factors and their effect on self-esteem are briefly described on the following pages.

Parental Influences on Self-Esteem

Frey and Carlock (1984) identified a representative list of "psychological pathogens" to self-esteem (pp. 25–31). Many of these are associated with parental influences. These "pathogens" may persist throughout life and, if so, may consistently keep self-esteem low unless someone or something intervenes. Some examples from their list, along with problems that might arise when these are present during childhood, follow:

1. *Expecting perfection.* Nobody has achieved this state yet, but there are a lot of people trying! Carrying a burden of "always trying to be perfect" out of childhood guarantees failure. Those who have learned to set idealistic or unrealistic goals for themselves are constantly frustrated, critical, and impatient with themselves and others, always trying harder and never quite feeling successful. Negative self-evaluations, which are formulated by the individual from perceptions of adult reactions, deeply affect their feelings about self. Unless a person learns to set realistic goals and acknowledge small steps on the way, self-esteem will remain low because the person will never feel adequate.

2. *Inconsistency and failure to set limits.* Though some people believe consistency is a myth, children often search for consistency and limits, apparently seeking the security that structure and predictability provide. When that is missing, the result is anger, insecurity, and hostility.

3. *Failure to give positive feedback.* Many parents and significant others assume that children know positive behavior is appreciated and only respond to negative or improper behavior. Being constantly reminded or punished when behavior is inappropriate and seldom being appreciated when behavior is appropriate creates feelings of inadequacy and inferiority.

4. *Failure to listen.* Failing to listen to a child indicates a lack of respect and communicates that the child or what the child is trying to communicate is not important. When this feeling is carried through childhood, it fosters additional feelings of inferiority and inadequacy that are sometimes expressed in anger or hostility.

5. *Rejection.* Consistent rejection critically affects an individual's self-esteem. The rejected child's basic needs are not being met, in some cases, deliberately. Death, divorce, severe illness, or being ignored can

all be viewed as rejection by a child, with the ensuing feelings of inadequacy, guilt, self-hate, or self-rejection.

6. *Being a maladjusted role model.* Children who model their behavior after an adult who is maladjusted often end up disliking themselves because of those behaviors. Their self-esteem is greatly diminished in such cases.

7. *Failure to help children adapt.* Societal and cultural values are being questioned more now than ever before. It is difficult for children to feel adequate in a society where values are shifting or unclear. It becomes even more difficult when children try to adapt to a different culture where values conflict.

8. *Forcing children into a pattern.* Sometimes parents try to fit children into certain behaviors or patterns that may restrict their unique development or be beyond their capacity. This is sometimes called "living vicariously" and creates frustration and feelings of worthlessness and inadequacy in both parent and child.

9. *Allowing and supporting procrastination.* Believing that one does not have the self-discipline necessary to complete a task contributes to poor self-esteem. The longer the child procrastinates, the more the feelings of inadequacy and worthlessness multiply. Concurrently, there is a loss of self-respect.

Frey and Carlock listed several additional pathogens and observed that "one can be the recipient of several of these dynamics" (p. 31). Each of these or a combination of several can be detrimental to a child's self-esteem.

Social Influences on Self-Esteem

A basic assumption in social psychology is that self-concepts are heavily influenced by social contexts (Bachman & O'Malley, 1986). Each of us has a long history of dependency during infancy and childhood where we needed to receive positive responses from adults. We were motivated to behave in ways that increased the likelihood of receiving these positive responses. As children we internalize adult standards in this manner and attempt to regulate our own behavior and react with positive or negative feelings about self at the perceived evaluations/reactions of significant adults (Kaplan, 1976).

Kaplan (1976) further noted that low self-esteem is thought to be caused by individuals' self-perceptions that either their behavior or characteristics do not meet personal standards valued by the social system; by self-perceptions that significant others do not value them positively or perhaps even value them negatively; or that they might not have developed "normatively acceptable coping mechanisms" that could protect them from the effect of "self-perceptions of failure or rejection by others" (p.790). Someone with a history of being devalued will most likely have low self-esteem. This can be said to evolve from two sources: first, an individual's history of negative self-evaluation and perception, and, second, perceptions of highly valued others in the environment responding to the individual with less than positive attitudes (Kaplan, 1975). An individual is more likely to value the attitudes of those persons "who were associated with need gratification or deprivation" (p.37).

Psychological Influences on Self-Esteem

Psychological determinants of self-esteem refer mostly to the type of defense mechanisms an individual can develop to cushion negative feedback or self-perceptions of being negatively evaluated or rejected. Protection of self-esteem is a primary developmental task of children (Mack & Ablon, 1983). These authors further maintain that it is "questionable indeed, whether human beings can deeply experience positive self-worth except as the result of a relationship" (p. 9). Everyone knows two basic truths about the self. The first is that the self is alone and private, and the other is "that one is a real self only to the extent that caring and reaching beyond the self continue" (Yankelovich, 1981, p. 240). Therefore, the second psychological determinant of self-esteem is one's feelings about the level of success within relationships.

The whole notion of connectedness or belonging to someone is central to the development of self-esteem. Belonging to a family, a culture, a community, or a school provides a connection to sustain a sense of worth. Lacking such a feeling, one is likely to feel not valued, or not of value, and retreat into a defensive posture to avoid the pain of feeling isolated, hopeless, worthless, and unconnected. "Virtually all maladaptive defensive patterns in childhood, adolescence, and adult life have as at least one major purpose, protection of the pain associated with lowered self-esteem" (Mack & Albon, 1983, p.38).

Physical Influences on Self-Esteem

Inherited physical characteristics such as physique, appearance, and handicaps also may influence self-esteem. The physical attributes an individual has inherited can affect others' perceptions and behavior. Others may respond negatively to an individual's handicapping condition or physical appearance, thus affecting that individual's self-esteem, even though the individual's initial self-perception may not have been negative.

Others' reactions to self are also influenced by maturation rates. Adults treat children differently at different maturation levels. Children who mature early are often treated as adults and develop positive self-esteem. On the other hand, those who mature later and continue to be treated as children tend to develop low self-esteem. Even when this latter group matures, they often maintain old self-perceptions and the corresponding low self-esteem. Maturation also affects mastery of developmental tasks. Social disapproval, maladjustment, and increased difficulty in mastering higher level developmental tasks are all possible results of delayed maturation (Frey & Carlock, 1984).

Environmental Influences on Self-Esteem

It is difficult to define the effect that environment plays in the development of low self-esteem. A person learns values and satisfies needs within the environment through social interaction with significant others. If needs are not met and a person's expression of beliefs and values meets with disapproval within the environment, self-esteem will likely be damaged.

An additional aspect of environmental influences has to do with the groups within the environment with which the person identifies. Each member of a group is evaluated by every other member. If the group is significant to an individual, these evaluations will affect self-esteem. For example, if a person's perception is one of not being valued by the group, low self-esteem is probable. Esteem is related to one's rank in a group rather than the rank of the group when compared to other groups (Rosenberg, 1965).

Cultural Influences on Self-Esteem

Self-esteem is also affected by the extent of one's identity with a broader group, a cultural or national group. If the culture or nation is not esteemed by other cultures or nations, those identifying with those cultures or nations may suffer low self-esteem. We see this occurring with minorities when they experience difficulty assimilating another culture's values.

Difficulties arise when minorities identify with their own culture, are accepted and develop positive feelings of worth within that culture, and then try "to make it" in another culture. This is particularly painful when the culture of origin does not seem to be valued in the new culture and the beliefs and values of the two cultures are divergent.

All of the above factors—parental, social, psychological, physical, environmental, and cultural—contribute to the development of self-esteem to the extent that each or all of these are valued or devalued by significant others who provide feedback. This feedback is both verbal and nonverbal, overt and covert, and dramatically affects how adolescents see themselves.

The Intervention Process

Frey and Carlock (1984) identified four phases in the process of intervention to build self-esteem: (1) identity; (2) strengths and weaknesses; (3) nurturing; and (4) maintenance.

The goal of the first phase of intervention, identity, is to help the individual gain knowledge and understanding of self. The authors caution about beginning anywhere else. Many helpers begin at a more advanced state and find their subjects unable to begin. Those with low self-esteem tend to focus on the parts of self that are negative. They find it difficult to focus on strengths because they tend to see little if anything positive about themselves. Furthermore, attempts to first intervene at the nurturing or maintenance phase meet with failure because individuals with low self-esteem see very little if anything about themselves that might be nurtured or maintained. Nurturing may be what the helper thinks they need; however, if they have low self-esteem, chances are this is a skill they have not mastered.

The identity phase is vital because it enables individuals with low self-esteem to become aware of themselves in a less lopsided or more balanced fashion. Helpers often omit this phase. It is important to be aware that entering the intervention process at this phase breaks down barriers and sets the stage for empowering individuals to sustain high levels of self-esteem, which is the ultimate goal of intervention.

Once the person with low self-esteem has a broad awareness of self, it is easier to move into phase two and recognize strengths and weaknesses. Individuals can examine or reexamine aspects of self and see them from a different perspective. Others can help in this process by providing specific, nonjudgmental feedback about positive and negative traits. The key is to provide this feedback in a five-to-one ratio, positive to negative, for optimal effect (Frey & Carlock, 1984).

Those receiving feedback must be taught to accept only what is true about themselves. Feedback refers to others' perceptions of behavior and is colored by their beliefs, values, attitudes, methods of expression, and self-esteem issues. It is important to teach screening skills so appropriate feedback can be absorbed. Individuals with low self-esteem tend either to accept all feedback or to deny it all. The screening process helps them establish information that is true and information that is a *projection from the giver.*

After identifying strengths and weaknesses, the third phase of intervention is learning ways to sustain the growth in self-esteem through nurturance. Learning to nourish or nurture oneself is a process of learning how to fill needs, how to change attitudes and perceptions that become self-fulfilling prophecies, how to give and get support or set up support systems, and how to find ways to enhance one's positive self-perception.

A final phase in the process of building self-esteem is that of learning how to maintain acceptable levels of self-esteem. This phase entails: (1) developing skills to change perspectives; (2) practicing risk taking; (3) learning new skills to ensure success experiences; and (4) identifying realistic goals and outcomes. Building self-esteem is an evolving process with the ultimate goal of sustaining high levels of self-esteem. Learning ways to enhance self-esteem becomes a lifetime project!

Activities and Strategies to Build Self-Esteem

Many resources are available that describe activities to enhance self-esteem. Examples of activities are provided for use at each step in the process. Readers are encouraged to use additional resources for more activities.

Phase One—Identity

Any activities that focus on the individual's self-awareness are appropriate at this stage. Awareness of feelings and thoughts about family and self are appropriate here. Many centering and imagery activities also are appropriate. Some examples are:

Values exercises—values clarification by Simon, Leland, Howe, and Kirschenbaum (1978) is a valuable tool to help adolescents identify what they believe. These structured exercises (see the two examples below) can be used with a group or with individuals.

What's in your wallet? (Strategy number 63, p. 329) This values exercise provides the opportunity to learn about what is valued through noting what we carry with us daily. Participants are instructed to pull out three articles they carry with them in their wallet (or purse). Individuals are then given the opportunity to talk about the importance of these articles in their life.

Personal coat of arms. (Strategy number 47, p. 278) Individuals are instructed to create their own coat of arms that will depict several aspects of self. Participants draw a coat of arms (or are given an outline of one), and divide it into segments corresponding to the number of topics to be covered. Some suggestions are to identify: (1) your greatest personal achievement, (2) your family's greatest achievement, (3) your greatest personal failure, (4) three things you would like to have said about you if you died today, (5) your personal motto, and (6) one thing you would like to accomplish by age 65. Further suggestions are included.

Polarities (Frey & Carlock, 1984, p. 117). Participants identify five qualities that describe themselves, and indicate the opposites of each of the qualities. They are then asked how they are able to own both sides. In groups of three or four, they spend 3 minutes acting out one side, then 3 minutes acting out the other side. Full group discussion centers around accepting the qualities that were listed as opposites, or the side of ourselves we disown, the "dark side." Participants also identify situations where some of these "dark side" qualities could be a help and then situations where some of the qualities listed first could be a problem.

Who am I? This activity has several variations. Frey and Carlock (1984, p. 122) suggest an individual think about the question "Who am I?" and identify a list of 100 or more responses, trying not to censor. Processing centers around themes and any omission of key areas such as spiritual, social, physical, intellectual, or emotional areas.

Another version is to have individuals think of the roles they play in daily life such as student, friend, brother, worker, sister, niece, and rank the 10 roles from 1 (most important) to 10 (least important). In the processing that follows, each person talks about what it would be like if the role were relinquished.

Trust exercises. Learning to trust self and others is an aspect of the identity phase that should be included. There are a variety of such exercises.

In the *trust walk or blind walk* (Stevens, 1971, p. 207), each person has a partner. In each pair one becomes a "blind" person and the other becomes the leader who is responsible for showing the blind person what the world is like. Later partners change roles.

The *trust fall* (Stevens, 1971, p. 263) can be done in a small group or with two people. In a small circle, one person (whose eyes are closed, hands and arms either clasped or hanging loosely at the side) falls backwards and is caught and gently passed around the circle. The circle begins with members close together and gradually spreads out during the exercise. The person is caught and gently returned to a standing position. A variation for this (Weinstein & Goodman, 1980, p. 46) is to have two people stand about 2 feet away from each other with palms out at chest level, facing each other. As they fall forward they catch themselves on the partner's hands, push off, take a step backward and fall forward again. They continue this process as long as they can safely do so.

Imagery exercises. The following exercises also are helpful in the identity phase.

Dreams of the future (Reasoner, 1982, p. 38, #6) requires adolescents to visualize the kind of person they would like to become, how they would like to be seen by others, skills they would like to have in the future, and so forth.

Treasure map (Gawain, 1982, pp. 11–12) is an actual, physical picture of a person's desired reality. This can be done by painting, drawing, or using pictures and words from magazines or photographs. The focus is on a particular goal or area of the individual's life and depicts the ideal situation, completed, as if it were already true. The person creating the treasure map must be sure to be included either in a drawing or by a photograph. The individual's image must be shown doing or having the desired objective. Make the setting real and believable and include affirmations. Gawain believes that the cosmic affirmation must also be included, "This or something better now manifests for me in totally satisfying and harmonious ways for the highest good of all concerned" (p. 12).

Additional imagery exercises can be located in *Awareness* by John O. Stevens (1971). Stevens's exercises are excellent and still very usable now. Gawain's *The Creative Visualization Workbook* (1982) is also helpful.

Phase Two—Strengths and Weaknesses

As individuals become more aware of themselves and become more comfortable with focusing on self and personal discussions, they will be better able to discuss strengths and weaknesses. It is important in this stage to provide information about giving and receiving feedback. Basically feedback should be phrased in behavioral terms and with no evaluative judgments. For example, "I was pleased when you remembered my birthday" is more specific than "You're a great person." Similarly, it is important to be able to filter feedback. Individuals must learn to filter out what is appropriate and what is not.

Managing your pig (Frey & Carlock, 1984, p. 127). This is an activity in which individuals can discover parts of themselves that they criticize or dislike. They can learn methods for changing or stopping these negative messages. Participants are asked to make a list of "things I get down on myself about" (p. 127). They identify their level of willingness to change each behavior according to a five-point scale, (a) "I am not ready to change this yet"; (b) "I am working on this one step at a time"; (c) "I want to work on this in the future"; (d) "I am confused about what I want to do about this"; and, (e) "I am working hard to change this" (p. 128). During this activity, participants set goals for change and assess the reality of these plans.

The following are variations for identifying strengths and are found in many sources. Some of the more specific sources are identified.

Personal descriptions. Each person in a group writes a description about another person, describing only positive aspects. These are placed in a hat, and each person chooses one description and reads it with everyone guessing whom it describes.

In another variation, called *stroke sheet* (Frey & Carlock, 1984, p. 129), participants have a sheet of paper pinned to their back, and everyone walks around and writes positive statements, words, phrases (strokes) on these papers, which are later read in the group.

Bombardment (Reasoner, 1982, p. 31). A 3 × 5-inch card, one for each group member, is passed around the group, and group members are instructed to write something positive about every other member. Group members receive their cards and can choose to read any or all of them aloud. A variation used by the author allows each individual to describe personal strengths for 3 minutes and then allows group members to contribute what they see as this person's strengths for 2 additional minutes. This variation is best used with a group that has already spent time together.

Slams and strokes (called "sticks and stones" by Frey & Carlock, 1984, p. 128) enables each person to provide feedback to another by relating something negative followed by something positive. One person volunteers to throw the "sticks and stones" (words) tailored to the groups' characteristics, designed to drag people down. After each statement, the group responds "It doesn't matter what you say, I'm still a good person. I'm OK" (p. 129). The response gets louder and more convincing as the insults continue. Processing must include feelings about being the one doing the insulting, as well as feelings about being insulted. This can also lead to discussion about useful processes for filtering negative communication.

Phase Three—Nurturing

Nurturing activities are designed to teach individuals how to nourish themselves and others. Once an individual has identified strengths and weaknesses and developed new awarenesses, it is important to continue the growth, like tending a new flower. Some positive feelings come from reinforcing strengths in self and some come from reinforcing strengths in others. As a person's self-esteem grows, weaknesses are minimized and strengths are emphasized. This is the purpose of the following activities:

Giving gifts (Author). The group can be any size and should be standing in a circle. One person volunteers to stand in the center with eyes closed. Other members of the group give the person in the center "gifts" such as hugs, a pat on the back, or a backrub. The person receiving these gifts cannot respond. Processing includes discussing both receiving and giving these "gifts."

Standing ovations (Weinstein & Goodman, 1980). Everyone feels good after a standing ovation! This activity can be used in any situation or group. The rule is very simple—if someone wants a standing ovation, that person says, "I want a standing ovation!" Others in the group provide the standing ovation. A variation is to structure the activity to have people disclose something about which they feel proud and then ask for a standing ovation.

I appreciate what you did today. You . . . (Reasoner, 1982, p. 31). This activity focuses on noticing pleasing actions people take toward each other, and allows the recipient to provide written, specific feedback about what that action was. The recipient writes a note to the person who did the deed saying, "I appreciate what you did today. You . . . ", completes the description, and gives it to the doer.

Mascot (Dusa, 1988). Choose a group mascot, name it, and have an adolescent hold it as a signal to others that he or she is having a bad day and needs nurturing. The mascot can be a stuffed animal, a book, or whatever the group chooses.

Relaxation imagery: The power of the mind (Frey & Carlock, 1984, p. 228). Participants rate their current degree of tension-relaxation from 0–100, 0 being the most relaxed and 100 being the most tense. They then create a list of things that are relaxing to them and a list of things they do well (competencies). Through a process of visualizing a relaxing scene, with as much detail as possible, alternating with items from the "competency list," participants learn how visualizing can affect mood and levels of tension and relaxation.

Lifting and rocking (Stevens, 1971, p. 266). In a small group of seven to nine people, one person lies on the floor and the others support and lift the individual, using a gentle rocking motion, and then slowly lower that person to the floor. Activity is nonverbal, but soft music can be used.

Phase Four—Maintenance

The maintenance phase entails learning ways to sustain acceptable levels of self-esteem. During this period activities involve goal setting, assertiveness training, risk taking, and learning the skills necessary to fulfill needs.

Building a support system (Author). Individuals divide a sheet of paper into four squares and label each as one of the following—listening, emotional support, emotional challenge, and reality check. Everyone on the list should be someone whom the individual trusts and who is nonjudgmental. Listeners listen, emotional supporters provide perceived support (mothers can be listed here), emotional challengers encourage the individual to stretch, question, confront, and challenge, and those in the reality check category provide confirmation of reality. First, individuals fill in each square with names of people available to them in each category. Next, participants list people who are possibilities to be included in an area and, finally, list the barriers to having these possible supporters actually become a functioning segment of the support system. There are two more categories that can be added. Technical supporters are those who know an individual's job and can provide feedback, and technical challengers are those who encourage a person to stretch, question, confront, and challenge in the technical/professional area. Discussion includes scrutinizing the barriers to see whose barriers they are. This activity can be followed with a planning and goal-setting activity to actively eliminate the barriers and incorporate any or all of those "possibilities" into supporters who are present for the individual.

Write a letter to yourself (Frey & Carlock, 1984, p. 140). Participants write themselves letters describing what they have learned about themselves, what they are concerned with about themselves, what they really like about themselves, and what they wonder about themselves. They then give the letter to someone who will mail it back to them a couple of months later.

Any special seminars or workshops that provide skills training would be helpful during this period. Specific information about communication (verbal and nonverbal); introducing the idea of group rules; helping adolescents and parents develop parental support; computer training; career programs; mentorship programs for peer, male, female, and minority adolescents; and problem-solving and conflict-resolution activities all help an individual to maintain appropriate levels of self-esteem. Additional activities might include a variety of human potential seminars on building skills such as study skills, library use skills, math skills, and relationship building skills.

The activities mentioned are samples of the types of activities that are available in those sources identified as well as in other books on self-esteem.

Case Study of a Success Program

A recent program piloted in Washington State serves as the basis for this case study. The program, called the Integrated Learning Model (Crow & McKisson, 1985), focuses on integrating career development and learning through a program that provides "connectedness" for those at-risk adolescents involved. The program's developers, Crow and McKisson, describe the program as a powerful experience for the adults involved as well as for the adolescents.

Motivation to develop this curriculum stemmed from experiences both authors had with inmates at local correctional institutions. As this population went through a program about the workplace, career issues, and learning styles, comments such as "I never thought I could learn. I was always dumb"; "I never thought of having a career—I never have seen myself as part of the workplace" were made.

Most of the participants in these classes disclosed that in one way or another they had always seen themselves as losers. Sometimes these messages came from family sources and sometimes from school as they received information about how they operated in the world. Because self-esteem is an individual's evaluation of self-worth based on information received from successes and failures and on information received from others, it could be suspected that these individuals have low self-esteem.

As a result of these experiences, Crow and McKisson (1985) developed the Integrated Learning Model. The program consists of four components: learning and thinking, career development, basic skills, and interpersonal and social skills. These four components are not separate but integrated into a curriculum. For example, the career development class has been built around learning styles and includes activities to promote learning of interpersonal and social skills. In all classes, a primary focus was to help the adolescents find their "gifts."

The following paragraphs describe the most recent program:

Participants

Forty three 14- and 15-year-olds were referred by school counselors, teachers, and in some cases, parents. The adolescents were referred for a variety of reasons, including low self-esteem, low achievement, withdrawal/isolation from people, truancy, or trouble with the law. Joan and Andy, the two adolescents mentioned at the beginning of this chapter, were members of this group.

Faculty

Four faculty members taught the four components, and four teachers were assigned 10 to 12 adolescents to follow for the 4 days at the camp. The teachers attended classes with the adolescents and were involved in all the activities. They monitored their group, debriefed them each evening, and provided support. They also served as local resources for the four faculty members. The adolescents stayed in cabins with a peer-age counselor. During the debriefing when the adolescents brought up instances of an activity they disliked, the teachers responded nonjudgmentally with questions like: "What is there about that activity that bothered you?" "Where did that come from?" "Does everyone feel that way?" For example, during the stay there were many activities where adolescents had to hold hands. In a subsequent debriefing session, one of the boys said that he did not like that particular activity. The response was, "What was it about the activity that you disliked?" The answer was, "Because boys had to hold hands." "Where did that come from?" led to a more general discussion of how everyone felt. The result of the conversation was that each person was heard, and they discovered that everyone did not agree. This opened the way for alternative ways of thinking about the issue.

Program

Adolescents attended four classes over the 4 days: finding your gift, learning to learn, the future workplace, and thinking. There were many activities in which all were involved. One was an experience called Ropes (described later). There were two underlying goals in all these classes and activities: (1) to help each participant focus on personal gifts, and (2) to enable each participant to make connections with others.

Opening night (identity phase). Icebreakers were designed to help individuals make contact with each other and begin to focus on gifts. For example, each person had to fill out a bingo card with 20 squares containing 20 different descriptions such as "I am left-handed," "I am good at sports," "I like to write," "I like movies," "I am a good cook." They moved around the room finding a person to fit the description in each square and asked that person to sign the square. They progressed to Bolles Party Game, in which people move into different groups based on their interests and discuss what they do that brought them to a particular group. Through this process, in which they move two more times to second- and third-choice groups, the group began to focus on gifts.

This first evening participants also took the Kolb-McCarthy Learning Style Inventory. They were divided into four groups according to the results for further discussion of their learning styles. This too was used during the camp to help them focus on their gifts and to encourage them to "stretch." Individuals were introduced to the concept of a standing ovation discussed previously.

Finding your gifts (strengths and weaknesses, nurturing, maintenance). This class had individuals complete activities where they identified strengths, skills, talents, and areas that were a "stretch" for them. They studied goal setting by going through a process of identifying challenges as "mountains to climb" and areas in which they were actively trying to improve. Through creating their own metaphors to describe themselves, they related their gifts to these metaphors and planned strategies to share their gifts.

Thinking (maintenance). This class combined creativity with problem solving, decision making, conflict resolution, risking, and job hunting to address many of the issues adolescents face. The activities encouraged the individuals to be creative to solve a problem and to look at other possibilities.

Learning to learn (identity, strengths and weaknesses, maintenance). Many adolescents identified as being at-risk have difficulty with schoolwork, so this class concentrated on strategies of learning. Discussions helped the individuals understand how they learn best, what excites them about learning, and what turns them off. Improving memory, test-taking techniques, note taking, asking questions, solving special test questions, and perceptions were all tools for learning that were taught in this class.

The future workplace, gifts applied (identity, strengths and weaknesses, nurturing, maintenance). This class described what all individuals should know about the workplace and helped them look at their gifts and think how these gifts would transfer to the workplace. They also became aware of the skills everyone will need in order to find or create a place for themselves in the workplace.

Ropes activity/class (identity, strengths and weaknesses, nurturing, maintenance). The theme of this class was teamwork. Each team was made up of 10 to 12 members, including some adult staff. The team was taken through a course out-of-doors, and as they encountered an obstacle, the teacher/leader described the dangers and the goal. The team decided as a group how they would successfully overcome the obstacle and reach the desired goal.

Trust exercises were initiated to develop team trust, and then the teams approached the first obstacle. The following are some examples of the "obstacles":

The individuals were told they were in a hot desert and they had to move to a cooler place. They could not, however, walk on the ground.

Their only mode of transportation was two 2' × 4's lying on the ground, with several pieces of knotted rope threaded through holes in the boards. As a team, they had to decide how to "save themselves."

As they walked through the woods, they came upon a large revolving spool suspended between two trees, blocking the path through which they had to pass. Their task was to decide how they would get to the other side of the revolving spool without touching the ground.

Then they came to a shallow creek. They were told the brook contained piranhas, so their feet could not touch the water. A large tree limb with a long rope attached to it extended over the brook. Obviously each member of the team had to swing over the brook. The problem was to get the rope within reach so they could move to the other side.

Each of these "obstacles" required everyone to work together both to decide upon a solution and to carry it out. It involved trust, risking, and new challenges for many participants. The course was created "to promote cooperative problem solving and to enhance self-concepts through an interesting series of carefully planned physical and mental challenges." All groups were closely supervised (Crow & McKisson, 1985, p. 1).

Hiking (nurturing). Participants hiked 2½ miles up a mountain where they could view Mt. St. Helens and Crater Lake. Evening activities included campfires, skits, and activities that encouraged individuals to challenge themselves and learn more about their greatness (identity, strengths and weaknesses, nurturance).

The faculty's assessment was that the individuals generally regarded the first night's exercises with some reserve. The first group went through the Ropes Course the next morning, and the change in the group after completing the 3-hour experience was marked. This transformation was evident in each subsequent group. The process of working together, each member contributing to the successful completion of the tasks, brought participants closer together.

The faculty saw the participants make connections with each other. As they worked together and learned together, some of their barriers came down. The "Friendship Circle" (nurturing) on the last night found all individuals more open about their feelings, although some participants retained some of their initial reserve. The emotions expressed that night demonstrated to the staff that bonds had been established.

Faculty observers reflected on their feelings about the success of the 4-day experience. They saw individuals become more open, more willing to risk, and much more positive about what they each had to offer others. They saw them helping each other, sharing, believing in themselves, emerging as leaders, and often surprising themselves. One faculty member described the experience as "powerful" for both the adolescents and faculty.

The real evaluation came from the participants. Some selected comments in response to the question, "What have you learned?" follow: "I learned confidence in myself; I learned that I have lots of talents; I learned I can voice my opinion"; "I learned that I was a leader and how to improve myself in school and in work"; "The teachers are great, and if you do something wrong, they still treat you like a person"; "That I'm just as good as anybody else, and when I get afraid don't keep it in, go to a friend or someone for help, that there is a place for me in the world"; "That I could trust other people"; "That I can get along with others better than I thought"; "I learned that there is caring and nice people, how to trust and work with others. I also learned that it's hard leaving the ones you love and care about!"; "I have more confidence and more courage"; "I'm nice and helpful. I have some stupid problems. I'm worth something"; "You find out you're not the only person with problems. You feel better about yourself and what you can do"; "I didn't know so many people could care."

Joan was one of the adolescents who emerged as a leader during the experience. She organized other persons into work details and later told staff members, "I gained confidence in myself!" She told them that she had discovered that other "kids" liked her and that she had gifts to offer others. She was excited about applying her newly acquired knowledge about herself at school and was optimistic about her next year in school.

Andy kept to himself during many of the activities. He participated sporadically and usually could be found on the fringes of the group, listening quietly. Occasionally he would make a contribution and then withdraw. The last evening at the final event he left to go for a walk. Others noticed he was missing and went looking for him. When they finally found him, they expressed their genuine concern for him. When the group returned, Andy went to a staff member and in a surprised voice said, "They were really worried about me!" Though he wasn't observed talking with those in the group who found him, he did "hang out" with them for the rest of the evening. However, the next morning when he appeared for the trip home, he seemed withdrawn once more. He said goodbye and told a staff member that the experience was "okay."

A young lady preparing to leave the camp got off the bus several times to make the rounds and hug everyone. The group leaving the camp was a different group than the one that had arrived 4 days earlier.

Conclusions

In our society, young people exhibit deviant behaviors daily. There is evidence that many adolescents demonstrate at-risk characteristics.

These young people are considered to be at risk because, unless they are helped to succeed, they too will become part of the deviant subculture. Research has shown that there is a connection between how one feels about oneself and how one acts (Kaplan, Martin, & Johnson, 1986; Kaplan, 1975; Marston, Jacobs, Singer, Widaman, & Little, 1988). Low self-esteem is an issue that must be confronted as a cause of at-risk behaviors.

This chapter has identified specific symptoms of low self-esteem, factors that influence self-esteem, and an intervention process. The activities designed to be used with adolescents are not extensive, and readers are encouraged to collect and create their own. The goal is to reach all adolescents, particularly those who are at risk, and to give them a chance to succeed. The Joans and Andys need guidance and support.

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Chapter 6

WHEN LIFE SEEMS DARKEST: ADOLESCENT DEPRESSION

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Introduction and Problem Statement

The incidence and nature of depression during adolescence are controversial topics (Esman, 1982; Oldham, 1978). Historically grounded in traditional psychoanalytic theory, depression is a manifestation of conflict between the ego and superego. Yet, neither of these components are thought to be fully present before late adolescence (Garrison, Shoenbach, & Kaplan, 1985). As a result of this model, mental health researchers and practitioners for decades discounted the existence of depressive disorders during childhood and early adolescence. Nevertheless, adolescent depression is a significant phenomenon and deserves full attention.

In this chapter, we will present a variety of perspectives that address the symptoms, causes, and treatments of adolescent depression. After briefly discussing some research related to depressive disorders among adolescents, we will describe the case of Stacy, an adolescent who is struggling with depression, and use her situation as a means of presenting some of the causal models and related intervention strategies for this disorder. Finally, after describing these various strategies, we will advocate a purposefully eclectic and comprehensive treatment intervention designed to grapple with Stacy's depression from several points of view.

Authors' Note. The authors would like to thank Timothy J. Kigin for his previous work in this area.

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Review of Related Literature

Aspects of adolescent depression have been greatly influenced by psychoanalytic theory. For example, an important aspect of psychoanalytic theory is the concept of "adolescent turmoil." According to this conceptualization, all adolescents go through a period of developmental turmoil that may seem to be psychopathological. Behavior is attributed to a naturally occurring ego regression. Personality upheaval, inner unrest, and deviant behavior are considered normative expressions during the developmental period. As a result, the significance of depressive symptoms is minimized. These symptoms are thought to be a normal part of adolescence and, therefore, clinically unimportant (Garrison et al., 1985). In fact, as Robbins and Kashani (1986) suggested, clinicians who adhere to this perspective consider the absence of symptoms of adolescent turmoil to be pathological. Thus, due to the predominance of the psychoanalytic model of depression, childhood and early adolescent depression were discounted, and depression in late adolescence was ignored.

Some research refutes the concept of "adolescent turmoil" as a specific characteristic of adolescence (Rutter, Graham, Chadwick, & Yule, 1976). Indeed, Weiner (1975) concluded that no common picture of adolescent turmoil exists; that there is no consistent period of difficult psychological adjustment that adolescents outgrow, and that similar behavioral manifestations may be found in adult populations. It has been further suggested that many adolescent problems or maladjustments are not transitory but may lead to significant disturbances in adulthood (Garrison et al., 1985). Over the past 2 decades, there has been a resurgence of research attending to the prevalence of depression in all age groups. However, our understanding of adolescent and childhood depression has been retarded by the concept of "masked depression," which received growing support during the 1960s. This model suggests that, although depression is experienced in childhood and adolescence, it is not manifested as such. It is, instead, masked by other behaviors or symptoms not usually thought to be depression, such as irritability and hyperactivity, aggressiveness and delinquency, somatic complaints and hypochondriasis, anorexia nervosa, obesity, poor school performance, school phobia, loss of initiative, social withdrawal, and sleep difficulties (Carlson, 1981; Carlson & Cantwell, 1980; Davis, 1983; Husain & Vandiver, 1984).

Although frequently utilized in the literature, the concept of masked depression is difficult to validate, is controversial, and has been refuted in research (Carlson & Cantwell, 1980; Cytryn, McKnew, & Bunney, 1980; Kovacs & Beck, 1977). For example, Kovacs and Beck concluded that "masking behaviors" are better conceptualized as presenting complaints. Carlson and Cantwell suggested that these complaints may meet criteria for other disorders, such as behavior disorders, but to the astute clinician depression will be identified and, therefore, unmasked. Cytryn et al. (1980) further caution that, when making a primary diagnosis, practitioners should determine whether the depressive equivalents or the depressive symptoms dominate within the client.

The criticisms for both the masked depression model and the concept of adolescent turmoil as explanations for depressive symptomatology have led to current acceptance in the research literature that depression exists across all age groups (Carlson & Cantwell, 1980; Cytryn et al., 1980; Puig-Antich, 1982; Reynolds, 1984). This general agreement about the presence of depression in adolescence has led to the opinion that adult diagnostic criteria can be useful for both adolescents and children (Reynolds, 1984). Given this consensus, it is appropriate to further describe the procedures for the diagnosis of depression among adolescent populations.

For the last 3 decades, the classification system most widely used has been the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. The revised, third edition of the manual, referred to hereafter as the DSM-III-R, was published in 1987. The DSM-III-R system of classification helps to ameliorate the problems and controversies associated with general classification concepts such as "adolescent turmoil" and "masked depression." The DSM-III-R does this by providing a description of the diagnostic categories of depression without projecting specific philosophical orientations or debating specific arguments regarding depression classification (Levitt, Lubin, & Brooks, 1983; Coyne, 1986).

The DSM-III-R classifies depression into two categories. The first category is "Major Affective Disorder," which includes two subcategories, Major Depression and Bipolar Disorder. Both describe the presence of a full syndrome of depression. However, the major distinction between the two is that Bipolar Disorder includes the manifestation of a manic episode. The second category is "Other Specific Affective Disorders," which could indicate either a Cyclothymic (mild bipolar) Disorder or a Dysthymic Disorder, which are both conditions indicating that mood disturbance has been chronic or intermittent for at least 2 years, but without the degree of severity to warrant a diagnosis of Major Affective Disorder. A third category, "Atypical Affective Disorders," provides subcategories for those affective disorders that cannot be classified under either of the two previous categories. This includes Atypical Bipolar Disorder and Atypical Depression. Given this system of classification, it is evident that the identification and definition of depression can indeed be a complicated procedure. Nevertheless, the DSM-III-R is useful to the counselor and psychologist in that it provides a systematic vocabulary and consistent framework for conceptualizing and categorizing mental disorders including depression.

The DSM-III-R is widely used by researchers and clinicians for diagnostic classification of depression and is used in most clinical settings. It is considered a valid and useful system for diagnosing both child and adolescent depression (Cytryn et al., 1980; Pfeffer, 1986; Reynolds, 1984; Robbins & Kashani, 1986; Weiner, 1983). Furthermore, although the DSM-III-R describes some age-specific features of depression, it suggests that affective disorders are consistent across all age groups.

Even though current diagnostic criteria, such as those provided by the DSM-III-R, support the perspective that depression exists among all age groups, adolescent depression is still relatively neglected in the research literature (Kandel & Davies, 1982; Poznanski, 1984). Studies that do exist vary greatly in their definition of depression and in the methods utilized to determine the presence and severity of depression among adolescents. Because of these problems, the incidence of adolescent depression varies significantly across studies. Among adolescent clinical populations, for example, estimates of depression range from 3% to 33% (Albert & Beck, 1975; Robbins, Alessi, Cook, Poznanski, & Yanchyshyn, 1982). Despite limited and methodologically weak research regarding depression in normal adolescent populations, there is considerable indication that adolescent depression is a significant problem (Garrison et al., 1985). For example, Reynolds (1983) reported that 34% of a large sample of high school students were at least mildly depressed.

In addition to some of the problems mentioned above, research in adolescent depression lags behind other areas because of major flaws in methodology. These tend to fall into three categories. The first is a problem of sampling differences. Most research is based on "samples of convenience," that is, subjects who are in various treatment settings, rather than normative populations. Similarly, the age of subjects varies greatly across studies, limiting the generalizability of findings to the normal population (Reynolds, 1985). Second, variations in assessment techniques or in the cutoff scores for levels of depression, when the same measures are used, severely limit the standardization of depression assessment. Finally, there has been ambiguity regarding the diagnostic criteria for adolescent depression. With only recent acceptance of the DSM-III-R system for diagnosing child and adolescent depression, concurrent with the diagnostic distinction between depression as a symptom versus depression as a syndrome, disparate rates of incidence among studies should not be surprising.

Causes and Treatments of Depression

A number of etiological and conceptual models of depression and related treatment strategies have been developed. The following sections of this chapter deal with these models of adolescent depression and provide various related treatment approaches. To explain these models and their treatment implications, we would like to present the case of Stacy. This case study will make it possible to discuss the practical and applied components of each model.

The Case of Stacy

Descriptive information. Stacy is a 15-year-old Caucasian girl and the only child of parents who are both teachers. Stacy's father, John, is a vocational education teacher at a community college and Stacy's mother, Theresa, is an elementary school teacher. The family lives comfortably in a middle-income neighborhood. Stacy is a shy, overweight youngster who is suspected of having a moderate reading disability (dyslexia). Stacy also has a slight speech impediment.

Background information. Stacy was an unplanned baby and her parents were ambivalent whether or not to have her. Stacy's mother took an extended leave of absence from her teaching career to take care of the baby. Stacy and her mother became very attached. As Stacy developed, her milestones became progressively delayed, but not out of the "normal" range for her age. Stacy was a sickly child and was a frequent patient at the family physician's office. Stacy is fearful of strangers—a trait she has exhibited since infancy. Stacy and her mom usually spent their days together until Stacy began preschool at age 4. Stacy had a great deal of difficulty beginning preschool. Her mother had to stay with her in the school for the first 2 weeks. Each day, Stacy would cry and refuse to go to school. Her "school phobia" continued throughout her early school years. Even now, Stacy often complains of illnesses to avoid school. She is fearful of new situations, preferring the safety of her family and familiar experiences. Her teachers describe her as an anxious, bashful, withdrawn youngster with few, if any, friends. Whereas many of Stacy's classmates are highly interested in peers and have developed solid patterns of peer relationships, she is becoming more isolated and withdrawn because she prefers her parents' company to participating in age-appropriate social events.

Parenting style. Stacy's mother, Theresa, is an anxious, emotionally volatile woman. Records indicate that she was overly solicitous of Stacy in earlier years. However, as Stacy has become an adolescent, her mood toward Stacy alternates between a detached disinterest and feelings of guilt at her inability to feel a strong sense of involvement in her daughter's life. When Stacy was young she would try new behaviors, but Theresa would not respond in any expressive way toward these attempts. Theresa also continues to be resentful of her career interruption and her husband's lack of involvement with Stacy. John spends long hours at the shop, teaching additional classes several nights a week, and avoids taking much responsibility for Stacy's discipline or encouragement. When Stacy's parents discipline her, they tend to scold and nag her to do better in school or to quit whining like a young child. There is little investment in actual behavior change. Both parents have attempted to "push" Stacy into school activities and age-appropriate relationships, but these attempts resulted in frustration and hopelessness. Stacy's parents believe they have tried everything to stimulate Stacy's interest in activities outside the family but they have failed in their attempts.

Resulting problems. Stacy's withdrawing, shy nature has become exaggerated recently. She has become the butt of some cruel comments about her weight and speech problems. Stacy's schoolwork has begun to suffer; she often does not complete or turn in assignments, listen to instructions, or use her time efficiently. Recently, a school counselor found Stacy hiding in the girl's restroom, crying and talking to herself as if she were a young child. Apparently, she had awakened that morning to find that her cat had run away. Upon coming to school, two girl classmates began to tease and to taunt her and she ran into the bathroom to hide. She expressed considerable gloom and despair to the counselor, stating frequently, "I'm no good." "I'm rotten." "Things will never get better." "There's nothing I can do."

Comprehensive Treatment Intervention

The case of Stacy presents a rather complex pattern of cognition, behavior, affect, and family structure, all of which undoubtedly contribute to Stacy's presenting problems. To determine the nature and severity of Stacy's apparent anxiety and depression, thorough assessment procedures, including a family intake, measures of anxiety and of depression, and clinical judgment should be utilized. It is obvious that Stacy suffers from deficient self-esteem along with depression, which is nearly always the case. This is a result of, and at the same time a contributing factor to, the family dynamics, poor school performance, fear of interaction within the school milieu, and peer rejection. Perhaps as much as any other emotional problem, depression is influenced by and influences other aspects of life.

Given the complexity of Stacy's development and family environment and in order to effectively treat the symptomatology of depression that Stacy exhibits, a comprehensive, multidimensional treatment strategy needs to be employed. The following plans are suggested for Stacy because they attend to her presenting complaints. Although the approaches may be altered or modified given more specific information regarding Stacy, the following models seem to provide appropriate strategies for an adolescent in her current situation. They are based on the belief that psychologists, counselors, and other mental health workers need a "working hypothesis" of the problem that is based on both the case at hand and various theoretical orientations that explain behavior. From these flow treatment interventions. For this case, we suggest several interventions that might be implemented. We do so from a deliberate eclectic stance. Readers need to assess their own theoretical knowledge and practical expertise and to utilize what seems most beneficial.

Adolescent depression is a complex phenomenon. It is supported by a complex interaction of thoughts, feelings, and behaviors within the adolescent and a complex tapestry of environmental factors. In Stacy's case, an effective treatment intervention should include a behavioral component with both social skills development and activity level increase; a cognitive component designed to identify, test, and modify dysfunctional beliefs related to herself, her family, and her environment as well as to monitor self-control; family interventions, designed to modify the communication and affective expression within the family and to improve the parents' consistency and effectiveness in being parents to Stacy; and school interventions designed to attend to Stacy's poor performance and moderate reading disability. Even prior to the current events in this case, attention should have been provided for early school intervention. Finally, some understanding of biological and pharmacological interventions is necessary. We begin our discussion of Stacy's case with this last issue.

Biological models of depression. Biological models of depression can be divided into two main categories, those that focus on the role of genetic factors and those that emphasize biochemical aspects of depression. Genetic factors of depression have been examined through twin/adoption studies among adults. Research has provided some interesting evidence (Kashani, Husain, Shekim, Hodges, Cytryn, & McKnew, 1981). For example, there is an average concordance rate of 76% for affective disorders in identical twins, versus 19% for nonidentical twins. Also, adoptees who experienced greater depression were more likely to have parents who suffered from an affective disorder. Problems exist, however, in that the specific nature of genetic transmission has not been determined, nor has the role of genetic factors in the etiology of depression for adolescents been systematically researched. Nevertheless, descriptive research shows that depressed adolescents frequently have depressed parents (Schwartz & Johnson, 1985). In Stacy's case we may also be dealing with a depressed mother or father, or both.

Another biological model of depression relates to biochemical issues. Neurotransmitter actions and their interactions with antidepressant medications have been the focus of much biochemical research on depression. Whether a primary cause in depression or a secondary component, some evidence suggests that abnormalities in the metabolism of neurotransmitters are present in depressives and can be counteracted with antidepressant drugs (Kashani et al., 1981; Snyder, 1975). Although genetic or biochemical causes of depression are uncertain in Stacy's case, pharmacological interventions may, nevertheless, be needed.

Pharmacological interventions. Chemical interventions are frequently used with depressed clients. For example, since the 1960s tricyclic antidepressants have been prescribed for young patients (Hodgman, 1985). Likewise, albeit to a lesser degree, monoamine oxidase (MAO) inhibitors and lithium carbonate have also been used (Reynolds, 1985). Although frequently used in the clinical setting, the effectiveness of antidepressants has not yet been completely established through controlled research. Uncontrolled studies have reported positive results (Puig-Antich & Chambers, 1978; Robbins & Kashani, 1986). Given this uncertain and scarce evidence for the effectiveness of antidepressants, especially with adolescents, their use with this population should be carefully evaluated and monitored (Medical Economics Company, 1987). Counselors and psychologists need to have a referral network available so that this aspect of treatment is not neglected. Stacy's mood seems to have deteriorated. Consequently, referral for medical evaluation with a possibility for pharmacological intervention is an important first step in her treatment.

Intervening in the school setting. The increasing rates of depression among adolescents suggest that prevention and intervention might be effected in the school setting (Forrest, 1983). This has particular implications for the school counselor, who is in regular contact with adolescents. Assessment strategies that may be effective should consider the adolescent's cognitive and affective characteristics, environmental stressors, and current coping mechanisms (Forrest). The subsequent treatment intervention may be similar to the one we propose later for Stacy. As suggested, treatment should include a mixture of affective, cognitive, and behavioral strategies. Evidence suggests that this type of approach has been effective in the school milieu (Coats & Reynolds, 1983).

Methods of prevention for depressive disorders are important for the practitioner, especially for the counselor in the school environment. Prevention takes two forms. Primary prevention advocates the removal of environmental or interpersonal characteristics that lead to a depressive disorder. Given the uncertain etiology of depression, this can be a difficult task (Reynolds, 1985). Nevertheless, early programs in the elementary schools that focus on affective education approaches, especially those that build self-esteem, are presumably very important. These need to be implemented. In Stacy's case, had a program been available to attend to her early school phobia and its underlying self-esteem issues, she may not have presented the later depressive crisis.

Secondary prevention, on the other hand, involves early detection and treatment of depressive disorders. Again, individuals who are most accessible to the adolescent become crucial (Robbins & Kashani, 1986). Early detection can conveniently and inexpensively be effected in the schools through group screening devices (Reynolds, 1985). If counselors and other school personnel utilize techniques of prevention within the school environment, it is highly possible that the frequency and severity of depressive disorders high-risk adolescents experience will be significantly minimized. Had such a prevention program been in place in Stacy's school, she may have been identified as being at risk earlier and appropriate interventions could have been implemented before the crisis stage.

It is reasonable to believe, and supported by the literature (Cytryn & McKnew, 1985; Petti, Bornstein, Delamater, & Conners, 1980), that a combination of pharmacological intervention along with counseling or psychotherapy might be most useful with Stacy and with most clients suffering from depression. In the case of bipolar disorders it is probably essential. The effectiveness of lithium carbonate with this type of depressive disorder has been well established. Of course, during a severe manic episode the behavior often causes problems that result in hospitalization. With adolescents, counselors and other practitioners need to be attentive to less severe mood swings or problems with a view to referral. Although the existence of a bipolar disorder does not seem probable in Stacy's situation, a medical referral for her depression remains important.

Family approaches. The above discussion of school intervention suggests an ecological perspective for the prevention or treatment of adolescent depression. An equally ecological approach is to attend to the family dynamics in Stacy's case. These dynamics are of obvious and considerable importance. Supporters of this perspective suggest that adolescents who experience depression provide evidence that their family may be malfunctioning. A maladaptive, homeostatic family system may be maintained when the adolescent performs the role of the "sick" family member. Not surprisingly, other family members may resist any positive change in the adolescent that may risk the homeostasis of family interaction. This reality necessitates the involvement of the entire family in treatment intervention (Guttman, 1983). This might be a factor in Stacy's family. A counselor using only an individually based intervention strategy may be doomed to failure. If the family system is not engaged, it may sabotage treatment and the ultimate success of ameliorating Stacy's depression. The role of the family in the successful treatment of the depressed adolescent is crucial.

The depressed adolescent affects and at the same time is affected by other family members. Even in psychologically healthy families, dealing with a depressed member can cause great stress for the family as a whole. Mental health workers must be aware of this interaction and of the fact that normal nurturance and family care may not be effective in dealing with the depressed adolescent (Robbins & Kashani, 1986). Similarly, clinicians must be prepared to work with all family members, especially parents who may also suffer from an affective disorder and compound the problems of the depressed adolescent. If the latter case is relevant, interventions must include appropriate treatment of the parent as well as the adolescent.

Having discussed the above issues of pharmacological considerations, referral responsibilities, school interventions, and family systems concerns, the mental health worker is still confronted with a very depressed 15-year-old girl who needs individual attention and support. The deliberate eclectic, multidimensional model we are proposing is built on the foundation of a solid interpersonal relationship between the helper and the client. This relationship incorporates the basic core conditions of empathy, warmth, and genuineness that are articulated by the Rogerian school. Although this approach forms the foundation and is, thus, a "necessary" condition, it may not be "sufficient" for many depressed adolescents. Hence, we suggest the specific strategies to be discussed. In this regard the psychoanalytic model may help in understanding some of Stacy's underlying dynamics.

Psychoanalytic models of depression. Because there are various predominant psychoanalytic models, our brief discussion will focus on the classical analytic position. According to this model, a distinction is made between grief, a normal response to loss of a love object, and melancholia, an intensely ambivalent love-hate relationship with the real or imagined loss of a love object. Individuals predisposed toward melancholia are highly dependent. This dependency creates hostility toward the focus of the dependency, but these negative feelings of anger are repressed and ultimately converted into self-hostility. Depression results from the negative impact of this "anger turned inward" on the self-esteem. In Stacy's case, her depression may be a result of feelings of hostility and anger toward her mother, father or both, which she has misdirected toward herself. Although this model has provided a stimulus from which other theories have developed, it does not provide validating empirical evidence or comprehensive strategies for the treatment of depression. Nevertheless, the psychoanalytic perspective provides an important conceptualization of the depression phenomenon. Let us turn now to two current approaches.

Current Approaches

The most influential approaches to depression are those that have demonstrated treatment success. These approaches fall into two categories: behavioral models and cognitive models (Lewinsohn & Hoberman, 1985).

Behavioral models of depression. Similarly to the proponents of the psychoanalytic model, behaviorists view depression as a result of significant loss (Kovacs & Beck, 1977; Schwartz & Johnson, 1985). Whether this be through changes in the environment, the loss of an interpersonal and reinforcing relationship, or one's failure to encourage and arrange for positive reinforcement, depression is seen as the consequential effect of inadequate or insufficient reinforcement (Ferster, 1973; 1974).

Lewinsohn's social learning theory provides a concise behavioral model of depression. This theory suggests that depressive behaviors are determined by the presence or absence of reinforcers and maintained through the reduction of response-contingent reinforcing events (Lewinsohn & Hoberman, 1985). Depression may be the result of limited positive reinforcement for the individual, which is determined by: (1) the number of potentially reinforcing events; (2) the number of these events available in the environment; and (3) the individual's social skills to elicit the accessible reinforcers (Levitt et al., 1983). Depression may also result from an excess of punishment, especially: (1) when it occurs at high rates; (2) when the individual is highly sensitive to punishment; and (3) when necessary coping skills to terminate punishment are limited (Lewinsohn & Hoberman). Unfortunately, the depressive behaviors stimulated by inadequate reinforcement are further reinforced by the concern or sympathy expressed by significant others. Eventually though, others avoid the depressed person because of the nature of his or her depressive behaviors, which minimizes positive reinforcement and further accentuates the depression (Lewinsohn & Hoberman).

Behavioral approaches. Two major behavioral strategies for treating depression are social skills training and programs to increase activity levels.

The primary goal of social skills training is to improve and increase the social skills necessary to receive positive feedback and reinforcement from others (Lewinsohn, Biglan, & Zeiss, 1976). Treatment focuses on the improvement of interpersonal style and on the development of skills, such as improved eye contact (Kaslow & Rehm, 1983). Modeling, feedback, role playing, instruction, situation logs, and homework practice are all utilized to help augment social skills and minimize the depression caused by an inability to elicit positive consequences. The prevalence of social skills deficits and the results of social skills training among adolescents have received limited attention. Nevertheless, such an approach seems especially appropriate for Stacy. Given the fact that she has had relatively little peer group interaction, "preferring the safety of her family," one might assume she has not developed effective social skills with her peer group. Indeed, she seems unable to cope with her classmates' "cruel comments." Thus, social skills training would seem to be a useful strategy to help lift her depression.

It is postulated that depression not only results from the limited reinforcement of poor social skills, but also from the lack of reinforcement that occurs when sufficiently learned and appropriate social skills are not utilized (Kaslow & Rehm, 1983). Increasing an individual's activity level, and therefore the frequency of potentially rewarding activities, may also increase the level of response-contingent reinforcement. This process will, in turn, reduce the behavioral symptoms associated with depression (Kaslow & Rehm). Here, again, a behavioral intervention seems to be an important consideration for Stacy. Unless she becomes more involved in more positive peer interactions and in positive and pleasant activities, she may have great difficulty in improving her depressed mood.

Programs designed to increase activity levels include establishing a mood/activity baseline, identifying current positive activities, increasing activities that are potentially reinforcing, decreasing activities associated with negative mood, and establishing environmental contingencies to reinforce both increased positive and decreased negative activities (Kaslow & Rehm, 1983). Scheduling more activity and using either self-managed or externally controlled reinforcement programs will also help to increase positive activities. This approach has had some results with adults (Kaslow & Rehm) and may prove useful with adolescents.

Cognitive models of depression. Research has supported the role of cognition in depression (Beck, 1967; Seligman, 1974, 1975; Rehm, 1977). The following cognitive models of depression are helpful in understanding this perspective.

The first model, proposed by Beck (1967), suggests that cognition and affects are interactive, and that the prior occurrence of cognition will determine a person's affective response to an event. If cognitions are distorted or inaccurate, the individual's emotional response will be inappropriate. Dysphoria may be the affective response of one's tendency to interpret experiences and events as negative or self-devaluative, indicating a cognitive role in the experience of depression.

Beck, Rush, Shaw, and Emery (1979) pointed to three cognitive components central to depression: the cognitive triad, schemas, and cognitive errors. The cognitive triad is composed of three negative thought patterns: a negative view of self; of the world; and of the future. Schemas, like personality traits, represent a stable cognitive pattern that individuals create in order to organize and evaluate information and events. People who experience depression develop schemas that distort environmental stimuli to coincide with a derogatory self-image. These dysfunctional or negative schemas are often created and exacerbated by faulty information processing, or consistent errors in logic, called "cognitive errors." The person suffering from depression uses these automatic cognitive errors to evaluate events, often leading to negativistic, categorical, absolute, and judgmental thinking (Levitt et al., 1983; Lewinsohn & Hoberman, 1985).

The second model of depression, Seligman's (1974, 1975) "learned helplessness" model, contends that depression exists in people who perceive that they have no control over their environment. They develop self-defeating attributions. They make internal (feeling responsible for an event), stable (the causes of an event will remain constant), and global (event outcomes will affect all areas of life) attributions for failure. In contrast, they attribute successful outcomes to external (caused by others), unstable (causes of events are transitory), and specific (situation-specific) causes (Kaslow & Rehm, 1983). This self-defeating attributional style results in the lowered motivation and reduced self-esteem common in depressed clients (Kaslow & Rehm). Although studies with adolescent populations are limited, self-defeating attributional style has been correlated with depression (Lewinsohn & Hoberman, 1985).

Rehm's (1977) self-control theory represents the third cognitive model of depression. Problems of self-control are manifested through deficits in three cognitive processes: self-monitoring, self-reinforcement, and self-evaluation. Depressed clients fail to view situations with an orientation to the future and tend to concentrate on immediate consequences of events (Gilbert, 1984). They selectively attend to negative outcomes and focus on immediate reinforcements. A negative view of the self, the environment, and the future results.

Similarly, depressed individuals tend to attribute negative events to either external causes beyond their control or to internal, unchangeable deficits in the skills necessary to create change. They tend to set high standards for positive self-evaluation, while at the same time exhibiting low standards for negative self-evaluation. Reduced self-esteem and an increased feeling of helplessness result from these maladaptive structures of self-evaluation (Lewinsohn & Hoberman, 1985).

Cognitive approaches. Depression treatment strategies flow directly from these three cognitive models. For example, Beck et al. (1979) developed a cognitive therapy with both behavioral and cognitive components designed to reduce automatic negative cognition with the goal of challenging the assumptions that maintain these faulty cognitions. Because clients often have difficulty utilizing cognitive tasks, behavioral strategies should be used first in the therapeutic process. Similarly, positive activities should be established and augmented through strategies such as role playing, graduated task assignments, assertiveness training, activity schedules, and behavioral rehearsal before cognitive interventions are employed (Lewinsohn & Hoberman, 1985). Thus, the earlier suggestions to involve Stacy in social skills training and to help her increase pleasant activities become even more important.

After these strategies are successfully utilized, emphasis is moved to cognitive interventions that emphasize identifying, testing, and modifying cognitive distortions. Strategies that have been successfully used (Kolko, 1987) include: (1) recognizing the connection between cognition, affect, and behavior; (2) monitoring negative automatic thoughts; (3) examining evidence related to distorted automatic cognition; (4) substituting a more realistic interpretation for distorted cognition; and (5) learning to identify and modify dysfunctional beliefs (Kaslow & Rehm, 1983). Such a strategy could be utilized with Stacy.

Seligman's (1981) treatment approach is an outgrowth of his learned helplessness model of depression. It challenges the faulty attributions of control and efficacy that depressed individuals often make (Kolko, 1987). Focus is placed on: (1) enriching the environment to assist in effecting more desired outcomes while decreasing unwanted ones; (2) developing expectations of control through control training; (3) reducing preference for unobtainable outcomes through resignation training; and (4) changing attributions to replace unrealistic expectations. Similar to other approaches, this model has had no reported applications with adolescent populations.

The final cognitive approach for depression is based on Rehm's self-control model. This intervention has been described as a primary prevention method, useful in teaching the skills necessary to avoid depression (Kaslow & Rehm, 1983). Kolko (1987) recommended that treatment in self-control involve specific training to, for example, monitor positive events and self-statements, engage in positive effect behaviors and cognitions, emphasize long-term positive consequences and develop more realistic and achievable goals, make more legitimate attributions, and create more frequent self-reinforcement. In Stacy's case, the depression is current. Devising ways to help her increase her positive and decrease her negative self-talk is very important.

There are two cognitive techniques that the authors have found to be particularly helpful. First, ask the client to repeat a standard, positive phrase, such as "I am a good and worthwhile person" *every* time the client pushes in a car brake while driving. Second, ask the client to write down on three-by-five cards a positive, affirming self-statement (e.g., "I am an honest and trustworthy person.","I am attractive and caring.") When three or four cards are completed, add one blank card and place them inside the client's cigarette pack. Each time a cigarette is taken, the client silently reads one of the cards. When the blank card turns up, the client must spontaneously make up a new, positive sentence.

Of course, if Stacy doesn't drive or smoke, these techniques need to be modified to fit her situation. Several principles are important. Negative thoughts cannot coexist with positive ones; positive thoughts need to be tied to new cues; and, positive thoughts need to occur with frequency.

Conclusions and Implications

The approaches mentioned above may be useful for the case study presented. Because we suggest a comprehensive and multidimensional approach to treating Stacy, the cognitive, behavioral, and family interventions described above might all be employed to attend to the multicomponent nature of her depression. Dealing with the family's limited support of Stacy; developing Stacy's social skills, level of activity, and interaction with her peers; and helping Stacy manage her cognition about herself, her environment, and her future are all plausible, and potentially necessary focuses of treatment.

Depression is an emerging, significant, and complicated mental health problem among adolescent populations. Its manifestation in adolescence is similar to that found in adulthood. It has been linked to other at-risk factors among adolescents such as suicide, school attrition, behavior problems, and substance abuse (frequently used as self-medication for depression)—further augmenting the difficulty in making appropriate diagnosis and establishing effective treatment interventions. Because research with normative populations is limited, further research is needed to gain a better understanding of the frequency and severity of this disorder and of the effectiveness of depression treatment models among adolescents. This is especially important given the relative lack of attention and recognition of this disorder among adolescent populations (Friedman, Clarkin, Corn, Arnoff, Hurt, & Murphy, 1982; Husain & Vandiver, 1984).

Depression can have a catastrophic effect on adolescents and on those around them. The prevention of depression and the provision of early treatment in the presence of this disorder are essential. Because parents, school counselors, and other school personnel play primary roles in the lives of adolescents, they must be especially aware of and responsive to the symptoms, causes, and related problems of depression. Identification, awareness, and quick response by parents and mental health professionals may be of paramount importance in avoiding the severe and devastating effects of depression on the adolescent.

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Chapter 7

THE SOCIETY WE LIVE IN: STRESS AND COPING

Art Terry and Sylvia Milliken

Case Study

This chapter begins with a case study of an at-risk youth. The authors invite the readers to think about some interventions they would use with him as they read this chapter. Some recommendations for areas of exploration will be presented after the applications and interventions section of this chapter.

Robert is a Black, 16-year-old who has lived in foster care homes for over 3 years. His parents don't have either the means or interest to care for him. He occasionally sees his father, but the father is not a significant influence in his life. He sees his mother even less frequently—the last time he saw her was over a year ago. She reportedly is a prostitute.

Robert has difficulties in his foster care home because he feels he is treated unequally and unfairly compared to the other youngsters living there (two biological children and 2 other foster children).

Robert does poorly in school. Although he seems to be of average intelligence, his GPA is only 1.2. Although his attendance in school is fair, he views school as difficult and irrelevant. He is very social and his charming personality is his greatest asset.

Robert has the usual teen stressors of low self-esteem, poor self-identity, and a negative body image. He is good looking, but thinks he is a little short. Some additional stressors are: lack of spending money; difficulties at home; lack of positive role models (especially from the Black community); difficulty with the discipline required for holding down a job; and poor coping skills.

Robert is flirting with gang membership and is becoming increasingly involved in their activities. He wears the gang "color" and hangs out with other gang members. He finds the violence exciting and fascinating. He is like a tourist voyeur on the gang vista. Although he is ostensibly aware of the downside of gangs, that aspect seems distant and unreal. He sees gang members as having the most money, power, and success when compared to other Blacks.

Introduction and Problem Statement

The Problem

Due to the rapid changes and incredible growth of knowledge, technology, and competition in our society, stress has become a major problem—particularly for children (Youngs, 1985). Youth experience stress, and their anxieties are just as stress-producing as those of adults (Henry, 1980). However, youth may not understand when they are reacting to stress and therefore may not know methods for dealing with stress. The challenge for concerned counselors, teachers, and other helping professionals who work with youth is to help young people and themselves learn to balance the stress in their life to ensure maximum physical, psychological, and social well-being. The purpose of this chapter is to present a holistic approach to stress management and coping skills for at-risk youth.

The objectives of this chapter are: (1) to present a case study for exploration in terms of effective stress coping skills; (2) to describe the stress response mechanisms and the effects of stress; (3) to review the literature by exploring the stressors in the daily life of youth in three areas—relationships, biological/developmental, and individual; (4) to examine applications and interventions—such as support systems and healthy coping mechanisms and interventions; (5) to further explore the case study; and (6) to make some general recommendations and suggestions for implementing the coping skills explored in this chapter.

The Stress Response Mechanism

The early work on stress was done by the 19th-century French physiologist Claude Bernard, and later continued by Harvard physiologist Walter B. Cannon. *Stress*, as a medical term, was coined by Austrian-born Hans Selye, an endrocrinologist at the University of Montreal. He provided the first significant breakthrough in stress research and is commonly referred to as the "father of stress" (Abel, 1974; Ivancevich & Matteson, 1980; Selye, 1956, 1975).

There are many definitions of stress. For the context of this chapter: "Stress is the perception of threat or expectation of future discomfort that arouses, alerts, or otherwise activates the organism" (Woolfolk & Richardson, 1978, p. 8). If prolonged, stress can fatigue or damage the body to the point of malfunction and disease. The agents or stimulus conditions are called the "stressors" (Abel, 1974; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Alarm. Selye labeled three distinct phases of the defense reaction: alarm, resistance, and exhaustion. Alarm is usually considered the most important phase. It involves a series of complex biochemical alterations. These cause the body's system to be speeded up, release energy-rich sugar to the blood, accelerate the blood clotting mechanism, and strengthen muscle functioning. In addition, breathing is speeded up, blood cells are released from storage into the circulation, the senses become keener, and the digestive system becomes temporarily inactive. The stress response causes the body to be geared up for "fight or flight" (Abel, 1974; Girdano & Everly 1979; Ivancevich & Matteson, 1980).

Resistance. During the second phase the body increases its resistance against the stressors. Unfortunately while resistance to a particular stressor is unusually high during the resistance phase, it is often unusually low to other stressors, leaving the individual more prone to illness (Ivancevich & Matteson, 1980).

Exhaustion. The third and final phase is called the exhaustion stage. Selye emphasized that each individual has a limited amount of "adaptation energy" to withstand stress. Once this has been expended, there is no known way to replenish it (Ivancevich & Matteson, 1980; McQuade & Aikman, 1974). Sometimes this stage is known as "burnout" because the body has used up its supply of life energy. Because of the incredible energy youngsters expend, they are particularly vulnerable to burnout (Youngs, 1985).

The Effects of Stress

In the book *Stress* by T. Cox (cited in Ivancevich & Matteson, 1980), the following classification of the consequences of stress are listed:

1. *Subjective effects:* Anxiety, aggression, apathy, boredom, depression, fatigue, frustration, guilt and shame, irritability and bad temper, moodiness, low self-esteem, threat and tension, nervousness, and loneliness.

2. *Behavioral effects:* Accident proneness, drug use, emotional outbursts, excessive eating or loss of appetite, excessive drinking and smoking, excitability, impulsive behavior, impaired speech, nervous laughter, restlessness, and trembling.
3. *Cognitive effects:* Inability to make decisions and concentrate, frequent forgetfulness, hypersensitivity to criticism, and mental blocks. (pp. 13–14)

In addition, the biological effects of stress are many and varied. Some are direct, whereas others—perhaps most—are indirect or have secondary results. Stress can be positive when it results in increased drive and self-motivation. However, most of the effects of stress are disruptive and potentially dangerous. Stress is strongly associated with many illnesses including ulcers, high blood pressure, heart disease, allergies, and headaches. Prolonged stress can also impair an individual's immune responses, decreasing the body's ability to fight invading bacteria and viruses. It is estimated that more than 50% of all medical problems are stress-related (Abel, 1974; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Review of the Literature

This section addresses causes of stress in the daily life of youth. It will be divided into three areas. The first area, relationship stressors, deals with factors or pressures that are exerted on the at-risk youth by others with whom he or she has a relationship. The second area describes the impact of biological and developmental stressors for developing youngsters as they strive toward autonomy. The third area covers the individual-level stressors that affect and characterize the youth as an individual.

Relationship Stressors

Peer pressure. High on the chart of relationship stressors for youth is the effect of peer pressure. There is sufficient evidence in the literature to show that as the youth becomes an adolescent, he or she uses social comparison in evaluating performance. Eleanor MacCoby notes that young people become increasingly aware of and sensitive to the reactions of others to self (Henry, 1980). The adolescent peer plays an important feedback role for the receiving adolescent. Adolescents become vulnerable to humiliation by their own behavior if it contradicts their desired image and if it differs from their peer group.

Sexuality. Issues around sexuality are very stressful for teens. Research indicates that the teen years are an age of uncertainty about sexuality—there is a desire to experiment, or to prove oneself in the sexual arena (Dean, 1972). For teens, there is often a constant questioning of adequacy and normalcy in regard to sexuality. In the senior high school age group, the Life Events List has been used to identify stressors. Three of the top five life change events causing stress have to do with sex and sexuality: getting married, unwed teenage pregnancy, and becoming a teenage father (Dean).

Sex has become an issue for more young people at an earlier age than in previous generations (Youngs, 1985; 1986). On the one hand, parents tell their children not to have sex until they are married, and on the other hand, the media (and often the parents' own actions) give a contradictory message of promiscuity and experimentation. Research indicates that nearly a quarter of the girls between the ages of 15 and 19 have had sexual intercourse before the age of 16 (Youngs, 1986). Indeed, in 1984, the rate of illegitimate births among teenage girls was almost double that of 1970 (Youngs, 1986).

Performance expectations of significant others. Today's youth are increasingly pushed into independence and self-reliance before they have the skills and abilities with which to cope (Youngs, 1985). One frequent stressor is that often each family member may be going in a different direction, resulting in families spending little time together. In addition, parents today are having fewer children, which can have the effect of increasing the pressure on each individual child.

Third, young people may be constantly pushed to compete with others and be the "winner" at everything they do. Even play, which used to be for fun and socialization, is often organized and structured for children by adults.

Most of the 60 million Americans under 18 aren't candidates for therapy, but mental health professionals and child experts are alarmed by the rising proportion of troubled youth (Whitman, 1986; Youngs, 1986). In fact, psychologist Nicholas Zill pointed out that "up to 35 percent of American kids suffer stress-related health problems at some point" (Whitman, 1986, p. 58).

Cultural considerations. In addition to the relationship stressors listed earlier, some cultural considerations need to be included. Edward L. Thomas (1965) is a medical physiologist who has studied the reactions to stress from a cultural perspective. He pointed out the drastic stresses of non-Western groups who are undergoing rapid, extensive acculturation.

> The whole pattern of life undergoes changes—diet, work, sleep, clothes, shelter, muscular habits, physiological rhythms,

> as well as family relationships, religion, ideas, and aspirations. All of these forces may generate physiological changes. (p. 166)

These individuals are subjected to adjusting to wholesale changes in life-style that can bring about "culture shock" and result in changes in appetite, hostility, anxiety, frustration, depression, and suspicion (Pedersen 1979; Thomas, 1965).

Biological/Developmental Stressors

The second type of stressors are the biological and developmental stressors that are connected with the process of individuation and separation. These include three areas: biological/developmental maturation; separation and individuation; and the psychological aspects that affect the youth during latency and adolescence.

Biological/developmental maturation. The first area of biological/developmental stressors has to do with the enormous biological and developmental changes that take place as a child moves through latency (age 6 to 11) and adolescence (age 12 to 16) and young adulthood (age 17 to 21). These changes cause stress for youngsters and all those in their environment. Physical maturation is escalated during adolescence, bringing about rapid physical growth and major hormonal shifts as the youth makes the uncomfortable transition into sexual maturation and adulthood. All this rapid change in the body can be both exciting and frightening for the youth and the family. "As a result of sexual maturation, new social expectations about sexual roles and norms of behavior are imposed by the family, school, peers, and the media . . . " (Preto & Travis, 1985, p. 26). Family support is critical to help the adolescent deal with these rapid changes. Unfortunately, at-risk youth often have little, if any, family support or stability.

Separation and individuation. "Although the process of identity formation and separation are really lifelong, puberty is a time of their acceleration" (Preto & Travis, 1985, p. 25). As the central nervous system matures, there is a shift from concrete to abstract thinking, and the youth begins to become an individual. Kaplan (1987) considered this to be a pivotal shift: " . . . this developmental advance in thinking between twelve and sixteen is from the more concrete, present-oriented, simplistic, right/good versus wrong/bad to the general, formal, logical, and abstract" (p. 151).

Separation involves the process of the child becoming separate from the mother, and individuation results from those achievements that establish the child as an individual. Kaplan (1987) clearly stated the distinction between separation and individuation:

> The separation process includes boundary formation, distancing, and disengagement from the mother culminating in the realization that mother and others are outside the boundaries of self. Individuation comprises the organization and control of perception, memory, cognition, and reality testing. (p. 139)

The role of the family plays in the adolescent's task of becoming a separate and autonomous individual cannot be downplayed. When the family is stable and supportive, it allows the youth to experiment and yet be protected so that individuation can take place. The parents need to be consistent with limitations, expectations, and consequences of behavior. They also need to show consideration for the adolescent's transition into adulthood and independence.

Parents can respond to the adolescent's dependency needs by setting clear limits and expectations, and, at the same time, respect the adolescent's struggle for independence by being flexible and willing to change rules in the family (Preto & Travis, 1985).

Psychological. With the advent of latency and the forming of the superego, one normally sees a shift from extreme dependence on the approval of parents to increasing self-control and self-awareness (Kaplan, 1987). Kaplan cited Laufer, who emphasized that in addition to separation from parents, the adolescent has the additional tasks of "mastering aggression, achieving heterosexual love relationships, and planning and commitment to future goals" (p. 152).

Kaplan (1987) divided the focus of typical adolescence into three phases: "first, the body and parents; second, sexual identity and the relationship to the other sex; third, goals, standards, and the relationship to society" (p. 153). This reorganization and redefining of self can bring about tremendous stress for the youth, and result in emotional and behavioral disturbances that can be lessened if the youth has a supportive, empathetic family.

Individual Level Stressors

The third category of stressors are individual-level stressors. This section includes a review of personality types, stability of the family, negative impact of a poor diet, and career/vocational stressors.

Personality types. Research has established that certain personality types are more prone to stress and illness than others. They have been classified as Type A Personalities. Type A personalities tend to be always in a hurry, take on too many tasks, find it difficult to relax, and tend to be demanding and critical, especially of themselves, and become defensive when criticized by others. They become impatient when confronted with delays, or with people they view as incompetent; they measure their success in terms of numbers (numbers of reports written, patients seen, etc.); they often try to perform many tasks at the same time; and they usually feel they have to do everything themselves rather than delegating. The are commonly referred to as "overachievers" (Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Individuals who do not exhibit Type A characteristics are known as Type B Personalities. They are able to: relax without feeling guilty; work without becoming agitated; be free from that sense of time-urgency of the Type A person; keep from getting angry easily; and be free from the need to display or discuss achievements (Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Many studies have shown the negative effects of Type A behavior on the heart. One well-known study is that of Friedman and Rosenman (1974). It showed a strong link between Type A behavior and heart disease (Girdano & Everly, 1979; Ivancevich & Matteson, 1980). "Changing Type A behavior generally consists of reestablishing priorities, allowing more time for each activity, and diminishing the total number of activities" (Ivancevich & Matteson, p. 184). Clearly, reducing pressure on youngsters to achieve, allowing them to mature at their own pace, and helping the Type A's to become Type B's would be recommended.

Stability of the family. Magid and McKelvey (1987) gave a chilling and shocking account of how society is creating more and more people who are without a conscience. They claimed that the lack of early bonding of the infant with a primary caregiver results in a lack of attachment and the development of an Antisocial Personality Disorder (APD).

> Factors responsible include: the increasing numbers of mothers working outside the home, the child-care crisis, the teen-pregnancy epidemic, a high divorce rate, increasing child abuse and neglect, the shambles of the foster-care system, and too-late adoptions. (pp. viii)

Without the early and continued support of the family, children are unable to form an affectional bond that allows them to establish and maintain healthy relationships. The consequence of this failure to bond is that youngsters are put at risk of becoming individuals with APD. They are "psychopaths, [who] express no remorse if caught in wrong-doings. They are aggressive, reckless and cruel to others" (p. 4).

Adolescents who run away from, or are put out of the home by their parents, are at high risk of experiencing violence and drug abuse. Also, without the stability of a supportive family, they are vulnerable to a life-style that includes "unemployment, underemployment, prostitution, and involvement with an abusive partner" (Preto & Travis, 1985, p. 30).

Negative effects of a poor diet. In the 1940s, Dr. Tintera found a connection between hypoglycemia (low blood sugar) and children with behavior or learning problems (Dufty, 1975). Hypoglycemia is often caused or aggravated by eating sugar. Cheraskin, Ringsdorf, and Brecher (1974) reported a study conducted by Rojas and Sanchi in 1941 about 129 juvenile delinquents who had been involved in crimes against persons. They found that 116 were hypoglycemic. Specialists have been successfully treating patients with behavioral problems by eliminating offending foods (Youngs, 1985). Youngs goes on to say:

> Studies since then have suggested that adverse reactions to foods can be one of the causes of hyperactivity, nervousness, stealing, learning problems, minimal brain dysfunction, depression, hostility, aggression, irritability, stress, and periods of confusion.
>
> Many foods have been found to be major causes of children's stress-related behavior problems. The primary offenders are soft drinks, cake, cookies, candy, ice cream, and sugared cereals. When these are removed from a youngster's diet, their behavior improves significantly. (p. 70)

Numerous other studies show similar findings of the detrimental effects of sugar on behavior (Bland, 1985; Davis, 1970; Smith, 1985). Youngs (1985) indicated that many experts in nutrition make the following recommendations for youngsters who are under stress:

- Eat at least three, evenly spaced, well-balanced meals each day.
- Consume adequate protein daily, whether animal or vegetable.
- Consume fresh fruits and vegetables daily.
- Use only whole grains.
- Include legumes and nuts in the diet.
- Use sparingly salt, dried fruits, coffee, tea, or tobacco.
- Allow a fruit, vegetable, or protein snack between meals or before your child's bedtime. (pp. 75–76)

It is also recommended that youth include supplements, such as calcium, Vitamins C, E, and B complex. These can actually strengthen the body's ability to handle stress (Bland, 1985; Davis, 1970; Youngs, 1985).

Career/vocational stressors. Another stressor for youth is the pressure caused by the overwhelming options and choices they are confronted with in terms of ideologies, careers, and life-styles from which to construct their future. The abundance of choices causes stress because it contributes to ambiguity (Youngs, 1985).

In addition to the difficulty of career choice and employment options, a young person faces an uncertain future that is further beclouded by possible annihilation through overpopulation, pollution, or nuclear warfare. There is often a sense of hopelessness in making decisions premised on a future that may not be. Adults often look at young people and assume that they should be grateful that they have their whole life ahead of them. What they forget is that from the adolescent perspective, if they are hurting now, they tend to think that the future will also be filled with pain (Youngs, 1986).

At-risk youth need guidance in many areas in order to destroy career and vocational myths concerning employability. They are entitled to the best occupational information available. They are entitled to know their skills, aptitudes, interests, and competencies in order to make wise choices. At-risk youth can be better prepared for the world of work as a result of the many training programs available. A few of these would include: internships; skills training through Private Industry Councils; cooperative programs that match employers and youth; Experience Based Career Education (EBCE) that enables youth to learn in one or more work sites under the supervisor of a team; and finally work experience programs supported by their high school.

Applications and Interventions

Support Systems

Helping youth, particularly at-risk youth, develop a support system of peers and adults is crucial. A good support program should include teaching youth to: understand the value of a support system; identify their support system; strengthen or add to that support system if needed; identify how their supporters "support them"; turn to others during times of stress; become aware of others' stress and how to be supportive to them (Youngs, 1985).

Peer support. This section includes two types of peer support—The Natural Helper Program (one-on-one support) and peer support groups.

In a recent videotape shown on television entitled *It Shouldn't Hurt to Be a Kid: The Natural Helpers Story*, the benefits of a peer support program for high school students was illustrated (Hirsh, 1988). The Natural Helper Program will be highlighted here because it is such an excellent example of positive peer support. At the time of airing more than 15,000 young people had been trained in the state of Washington. The program was started in 1979 at Mercer Island High School, located near Seattle. Young people are selected by their peers through a survey asking them to identify who they trust and what issues are important to them. The real strength of the Natural Helper Program lies in the fact that peers are so important to teens. When teens are in trouble, they tend to go to peers, and this program teaches those peers to be more effective helpers. The youth selected is called "A Natural Helper" because he or she is someone who already listens to, and is trusted by, other young people.

Teens are beset with problems from many areas such as drugs, sex, depression, suicide, and family disintegration. This program takes students who are already good listeners and teaches them to go beyond listening—to do something about the pain their peers might be experiencing. The program emphasizes that the young people selected are "helpers" and not "counselors." To become a counselor requires more skill and training than a 3-day retreat can provide.

Claire Roberts, one of the co-founders of the program, delineates some of its strengths: (1) Young people are selected by their peers as someone they trust and would go to with problems; (2) Each group is represented by "Natural Helpers" (jocks, hoods, heads, honor society, etc.) so that a true cross-section of the school is provided; (3) Adult support for the Natural Helper is provided by training adults from the school in this program also. These adults can be staff members at the school who are selected by the students.

The peer support group is another tool that can serve as a constructive experience for youngsters, particularly those who are intimidated, isolated, or fear rejection. Peer groups can help shape the experiences of the adolescent culture by determining the framework in which the adolescent gains appropriate, supportive experiences. Youngs (1986) listed some of ways a peer support group might be of benefit to youth:

- Developing a positive self-image;
- Adjusting to new situations and roles;
- Developing emotional balance;
- Reducing isolation by sharing experiences;
- Being exposed to positive role models; and
- Getting reliable feedback about behaviors and goals.

Crisis management options. In the areas of crisis, women tend to help each other more than men (Witkin-Lanoil, 1986). However, both men and women would benefit from learning techniques that teach them how to help themselves and others.

As indicated earlier, peers can be supportive to each other. However, when stress is at a crisis level, professional intervention by individuals who are specifically trained to deal with crisis situations is essential. A 24-hour crisis phone line should be available as well as a drop-in center where teens can freely and openly discuss their problems. Professional help is required if any of the following are reported: feeling overwhelmed, having suicidal impulses, having homicidal fantasies or impulses, or becoming increasingly dependent on drugs or alcohol to ease the pain.

Providing information. Making available information that is of key concern to youth, parents, teachers, counselors, and the community through various media and in various forms is another form of positive support. We suggest that written material addressing key issues in the form of books, pamphlets, and brochures be made available at drop-in centers, counseling offices, and throughout various locations so that youngsters and other interested persons might have easy access to them.

The media can help through presenting both local and national television programs and movies about some of the crucial issues presented in this book. Television can also help by having meetings on local talk shows or programs where youngsters are encouraged to talk openly about their concerns. Newspapers, libraries, schools, and community centers can also make a contribution by informing the public about some of these issues and having interesting films and speakers.

Healthy Coping Mechanisms and Interventions

Although it is beyond the scope of this chapter to provide a detailed description of all the approaches available to developing effective coping skills for stress management, we have listed nine interventions that we think are particularly effective. They are: Rational Emotive Therapy (RET), Self-Instruction Therapy (SIT), Stress Inoculation Training, Multimodal Behavior Therapy, Overcoming Test Anxiety, Time Management, Problem Solving/Decision-Making, Relaxation Techniques, and Physical Activity.

Rational Emotive Therapy (RET). Adolescents think that parents and the events in their lives cause them to feel the way they do. Thus, they often blame someone else for their feelings of stress and emotional upset. In doing this, however, they often neglect an important factor, the fact that the way they think determines their behavior, and thus their responses to stressful situations. Sometimes, even when they are aware that thoughts somehow lead to feelings, they might fail to realize that they actually have the ability to change unwanted or irrational thoughts voluntarily so that different emotional feelings will result. When teenagers practice cognitive restructuring, positive outcomes generally result. There is usually an increase in positive thinking, greater ability to cope with stressors, and a reduction of tension between the teen and significant others.

Albert Ellis, developer of Rational Emotive Therapy (RET), is perhaps the best known therapist for teaching people how to deal with irrational thoughts. Ellis reminds us that from time to time, most people engage in faulty or irrational thinking (Ellis, 1985; Kranzler, 1974). What people think or say to themselves before, during, or after an incident greatly influences their feelings and behaviors.

Practitioners of RET use a variety of cognitive, affective, and behavioral techniques. RET teaches clients to: challenge their own irrational beliefs; avoid the use of castastrophizing phrases such as "It's awful," "It's terrible," and "I can't stand it"; dispute overgeneralizations and global thinking such as "all," "never," "should," and "shouldn't"; separate their self-worth from their performance; use cognitive homework; learn to change their language; use rational-emotive imagery; and use role playing. RET ideas have been incorporated by many therapists and are presented in a variety of works (Corey, 1986; Ellis, 1985; Ellis & Harper, 1975; Kranzler, 1974).

Self-Instruction Therapy (SIT). SIT, developed by Donald Meichenbaum, is also effective in dealing with irrational thoughts and fears. It is a form of Cognitive Restructuring, which is a name given to techniques that deal with restructuring thoughts. Self-Instruction Therapy (SIT) also focuses on self-statements. However, this approach differs from RET in that Meichenbaum puts less emphasis on logical analysis of irrational beliefs and places more importance on teaching the child to learn to solve problems and to control his or her own behavior. Meichenbaum suggests a three-phase change process: self-observation; new internal dialogue; and learning new skills (Corey, 1986). The therapist assists the child to develop answers to four key questions: What is my problem? What is my plan? Am I using my plan? and How did I do? (Meichenbaum, 1977; Ramirez, Kratochwill, & Morris, 1987).

Stress-Inoculation Training. This is another cognitive restructuring technique developed by Meichenbaum. "[The procedures] are a psychological and behavioral analogue to immunization on a biological level" (Corey, 1986, p. 232). Clients are given opportunities to deal with relatively mild stimuli and gradually are exposed to stronger stimuli. In this manner, they build up a tolerance for stressors.

The stress-inoculation program has three phases. Phase one is the Educational Phase, which involves monitoring of self-statements and identifying their effect. Therapists are cautioned to be flexible and "respectful of the individual, cultural, and situational attributes of their clients" (Corey, 1986, p. 232). Phase two is the Rehearsal Phase. This consists of information gathering about situations that cause clients fear, making adjustments to lessen the fear, and learning methods of relaxation. Some coping self-statements typically rehearsed in phase 2 are: What can I do to prepare for this? How can I meet this challenge? What can I do to cope so that I won't feel overwhelmed? and How can I acknowledge myself? Phase three is the Application Phase, which involves practicing increasingly challenging behavioral assignments. This final phase is where all the techniques learned in the two earlier phases are put into practice in the client's personal life (Corey, 1986; Meichenbaum, 1977).

Multimodal Behavior Therapy. One of the most thorough interventions is Multimodal Behavior Therapy, which was developed by Arnold Lazarus. This model is effective because it is holistic and therefore deals with: minimizing the frequency of stress; preparing the individual, psychologically and physiologically, to withstand excessive stress; and educating the individual about exercises and activities that dissipate the physical by-products of stress arousal (Bailey, 1977; Girdano & Everly, 1979).

This approach was chosen to be highlighted because it is an eclectic approach, and therefore is easier to adapt for usage with the widest variety of clients. It draws from a number of therapeutic styles and techniques such as anxiety management, hypnosis, meditation, modeling, positive reinforcement, positive imagery, relaxation training, and thought stopping (Corey, 1986; Lazarus, 1976, 1986; Tolman & Rose, 1985). It also addresses the importance of diet, drugs, and exercise, which are effective tools in stress reduction.

Lazarus gives the client a preliminary questionnaire, followed by a detailed life-history questionnaire to get a clear picture of the client. The counselor helps the client develop skills by providing instruction, information, and feedback to the client, and by using homework as an important part of the learning process (Corey, 1986).

According to Lazarus, human beings are complex and therefore require multifaceted interventions (Corey, 1986). Lazarus believes there are seven major areas of personality functioning: behavior, affect, sensations, images, cognitions, interpersonal relationships, and biological/drugs function. He uses the acronym "BASIC ID" to represent these. The "D" represents the last component, which consists of drugs, medicine, nutrition/diet, hygiene, exercise, and the person's general biological functioning (Corey, 1986; Lazarus, 1976, 1986).

Overcoming test anxiety. Test anxiety is all too common for many students. Because taking tests is a necessary requirement for passing classes and graduating, and can be a positive indicator of the student's understanding of a subject, it is beneficial to provide an intervention that will help the student learn to break the "anxious cycle." Generally speaking, the reasons for test anxiety are three-fold: (1) poor study skills; (2) poor time management; and (3) negative self-talk.

Anxiety reactions can be a vicious cycle of obsessive thoughts. Such is the case when a student is experiencing test anxiety. The following technique combines several concepts, and it can be generalized to other areas of the youth's life such as dating, work, and improving self-esteem (Corey, 1986; Ellis & Harper, 1975; Lazarus, 1976).

A. Thought-stopping—of negative self-talk;
B. Systematic desensitization;
C. Setting realistic goals and acknowledging self; and
D. Establishing good study skills.
    1. Schedule definite study times;
    2. Study in same place if possible;
    3. Avoid distractions (T.V., radio, and people);
    4. Reward yourself when you keep the schedule; and
    5. Take smaller tests regularly and evaluate.

Time management. Alan Lakein (1973) pointed out the importance of time management in helping a person take control of his or her life. Teaching youngsters good time management will help them accomplish more effectively goals they set for themselves throughout their life. Lakein advised that "planning is bringing the future into the present so that you can do something about it now" (p. 25). Encouraging youngsters to know and respect their own personal values is crucial if they want to make effective, satisfying decisions they can live with (Gelatt, 1972; Krumboltz, 1966; Simon, Howe, & Kirschenbaum, 1972).

Some time management suggestions were given earlier in the section on overcoming test anxiety and developing effective study skills. However, for both short-term and long-term planning, it is important to make a list and set priorities based on one's own personal values. The youth determines the relative value of each item and places an "A" beside those that are of high value, a "B" beside those that are of medium value, and a "C" beside those that are of low value. Because the "A" items are of highest value, and will give the youth the highest return on investment of time, they should be attended to first. Next, the youth should work on the "B" items, and finally the "C" items. The youngsters' ABC's will probably change over time, but the process will serve them well throughout their life, both personally and professionally (Lakein, 1973).

Problem-solving and decision-making skills. Effective problem solving requires individuals to accurately and realistically look at their life and identify problems. A simple five-step process can help with this:

1. What is the problem?
2. How have I tried to solve this problem?
3. What other solutions are there?
4. Choose a plan and implement it.
5. Evaluate the results and recycle if necessary.

Youngs (1985) claimed the following benefits for children in terms of problem-solving ability:

> Children need to learn the skills of problem-solving in order to reduce stress, maintain stability, and achieve worthwhile goals. And as an adult, being an effective problem-solver will lead to success in all areas of life, both personal and professional. (p. 159)

The balance sheet model is a simple decision-making model and is useful when one has to choose between several alternatives. The youth lists the alternatives—one at a time at the top of the page on separate sheets of paper—and draws a line down the middle of the paper. On the left hand side the youth lists all the liabilities (cons) and on the right hand side lists all the benefits (pros). This works well for decisions that have a low impact or don't require a more thorough investigation.

Two other problem-solving approaches were presented earlier in this section—Self-Instruction Therapy and Stress Inoculation Training by Meichenbaum. Other problem-solving and decision-making models can be found in a variety of sources (Corey, 1986; Gelatt, 1972; Krumboltz, 1966).

Relaxation techniques. These interventions allow individuals to become better prepared, psychologically and physiologically, to withstand excessive stress. Meditation, biofeedback, relaxation training, listening to relaxing music, and doing slow stretching exercises such as yoga are all techniques designed to help the person slow down and achieve muscle and mental relaxation (Benson, 1975; Dean & Tager, 1981; LeShan, 1974).

Deep and regular breathing is generally associated with producing relaxation. In addition, by focusing on pleasant images (guided imagery) and thoughts, clients can learn to release tension. Another component of relaxation training generally includes having the client tense his or her muscles on purpose so they can begin to make the distinction between tension and relaxation.

Meditation can take many forms including prayer, focusing on slow, deep breathing, listening to slow movements of music, or using guided imagery. Or it can be a more formalized type meditation such as Transcendental Meditation (TM), developed by the Maharishi Mahesh Yogi, or the Benson technique, both of which are credited with bringing about such positive outcomes as "reduced heart rate, lowered oxygen consumption, and decreased systolic and diastolic blood pressure" (Ivancevich & Matteson, 1980, p. 218).

Biofeedback is a relaxation technique that teaches the person to become aware of the effect of thoughts, messages, and emotions on his or her physiological state. The typical biofeedback system involves the person being hooked up to an electronic instrument that monitors and gives feedback (visually or auditorially) while he or she is learning to control various bodily functions such as blood pressure, heart rate, or body temperature. This awareness and feedback allows the person to bring about a state of deep relaxation. Biofeedback has been successfully used in many relaxation training programs (Girdano & Everly, 1979; Ivancevich & Matteson, 1980; Youngs, 1985).

Physical activity. Although relaxation techniques will help alleviate the tension at the time of stress, there needs to be some aerobic exercise to completely dissipate the by-products created when one is stressed (Abel, 1974; Bailey, 1977; Girdano & Everly, 1979).

To maintain good health, it is generally recommended that one participate in some sort of aerobic exercise for a minimum of three sessions a week for a minimum of 20 minutes each. Some studies show that one needs to exercise at least five or six times per week to improve health and increase resistance to stress. Aerobic exercise is activity that increases the heart rate and circulation. This will maximize the supply of oxygen to the tissues, help remove waste products more efficiently, and tone the muscles. It often has a beneficial side effect by the releasing of endorphins, the body's natural opiates. The release of endorphins will cause a feeling of well-being and it is often what runners refer to as a "natural high" (Abel, 1974; Bailey, 1977; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

"Depending of the individual's coping abilities, a stimulus is perceived either as challenge to control with the flight-fight defense, *or* as an inducement to conservation-withdrawal (a helpless response) with depression" (Henry, 1980, p. 2). Once the fight or flight response is set in motion, it is best to use some aerobic physical activity such as jogging, swimming, or riding a bike, which will accelerate the dissipation of the stress products that are flowing through the body in order to prevent damage to the body organs.

Martial arts and yoga exercises are included in many Eastern approaches to wellness. These forms of exercise are said to tone muscles, help overcome fatigue and stress, and generally strengthen the body. Many books have been written to introduce the Westerner to the use of these techniques (Carr, 1973; Dunne, 1966; Hittleman, 1973; Maisel, 1963).

Case Study

Checking the Fundamentals

The authors feel that three areas need to be explored with Robert and with every client in order to provide effective treatment. Those three areas involve: (1) checking to make sure the client is not in crisis; (2) determining if there is child abuse or neglect; and (3) doing an assessment for chemical dependency or substance abuse. If any of these are present, they need to be dealt with first.

1. *Is he in crisis?* We feel that Robert is not in crisis because of the following: no suicide thoughts or plan; no obvious signs of depression (for example, no sleep disturbances, no eating problems, no digestive disturbances, or lethargy); he is holding down a job; and he seems energetic without being hyper.

The helping professional can look for psychological signs of stress, using what Witkin-Lanoil (1984; 1986) called the six D's as a checklist. They are: defensiveness; depression; disorganization (or confusion); defiance; dependency; and decision-making difficulties. If any one of those is evident, appropriate action can be taken.

2. *Is there child neglect or abuse?* Because of the home life Robert had during his formative years, it would be valuable to explore this area with him. We recommend that readers refer to the chapter in this book on this area. He currently has a safe place to live and his daily material needs are being met.

3. *Assessment for chemical dependency or substance abuse.* Most schools or counseling centers have excellent tools for this. We recommend that this be done with Robert. In addition, a physical exam might be warranted as well as an exploration of eating, sleep, and exercise habits. Multimodal behavior therapy has some excellent assessment tools to evaluate the balance in a person's life in terms of drugs, diet, recreation, and physical activity.

Additional Interventions

Some other key areas to explore with Robert in terms of stress management are: career/vocational assessment; developing positive peer support; challenging irrational thinking; modeling and role playing; and goal setting, time management, and budgeting.

4. *Career/vocational assessment.* What life skills does he possess and needs to develop in order to become successful? What career information systems would be helpful? Would short-term training be help-

ful? Robert has a strong interest in working with animals and is currently in a work-study program that allows him to do that. He has a limited interest or motivation in continuing with school, and in addition, is somewhat hampered by limited funds. Therefore, short-term training and education would probably be the best for him.

5. *Developing positive peer support.* Robert is sociable, comfortable around others, and a natural leader. We think he would be a good candidate for a peer support group. This would probably enhance his self-esteem and confidence, and could serve as a safety net for him by providing a network of resource people.

6. *Challenging irrational thinking.* Robert would benefit by using RET and SIT to work through some of his faulty and irrational thinking about gangs. Providing accurate information about gangs might help to diffuse some of the glamour and give Robert a more realistic picture of the danger of gang life.

7. *Modeling and role playing.* Robert would benefit from positive modeling and role playing (especially of Black youth and adults) to develop some new behaviors. Such modeling and role-playing could take place in the Independent Living Program (ILP). The ILP was created to help youth who are living in foster care or are on the street to become independent. Many of the teens and staff members are from the Black community and could provide positive role models for him. They also could encourage him to become more involved in the community and give him opportunities to develop his leadership potential.

8. *Goal setting, time management, and budgeting.* Robert has expressed concern and interest in these areas, so they would probably be helpful for him. These interventions can also be generalized to other areas of his life. The counselor might ask Robert to commit to counseling sessions for a certain length of time. The counselor would act as a facilitator to ensure that the goals are reasonable and achievable.

Recommendations and Implications

In this chapter several areas about stress were explored. The first two sections included a case study, a statement of the problem, the stress response mechanism, and the effects of stress. In the review of the literature, three types of stressors were explored: relationship, biological/developmental, and individual. The fourth section presented applications and interventions in terms of support systems and healthy coping mechanisms. The fifth section further explored the case study in terms of checking the fundamentals and presenting additional interventions that the authors felt would be of value to apply to Robert. This final area deals with recommendations and implications.

From the foregoing evidence, it seems clear that there are several key elements in effective stress management, and that one would benefit from taking a holistic view in tackling this complex challenge. We recommend the following: implementing peer support programs such as "Natural Helper"; establishing counseling centers; establishing a crisis center with 24-hour phone lines; having adequate assessment tools; offering local workshops to those in the helping professions to keep them current on crucial data and interventions; and making information available through various means.

Finally, the severity of stress depends, to a large degree, on the predictability of the situation, the person's belief in his or her potential for control, the individual's evaluation of the situation, his or her feeling of competence, and the presence of social supports. Stress-resistant individuals tend to be committed to their work and social relationships, feel in control of life events, view change as a challenge, and recognize the need to balance work and play (Abel, 1974; Ivancevich & Matteson, 1980; Youngs, 1985).

The evidence is clear that stress is costly and has strong effects in subjective, behavioral, cognitive, and biological areas. We cannot afford, either as individuals or as a society, to be ignorant of the toll excessive stress can take on the lives of our young people. Although they need a certain amount of stress and tension to be fulfilled and challenged, it is the task of parents, teachers, counselors, and others in the helping professions to help prepare youngsters—both physically and mentally—to prevent and withstand excessive amounts of stress. Helping professionals need to develop ways of assessing stress in youngsters, identifying which youngsters are at risk, and then designing appropriate programs to help them successfully meet the challenges of life.

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Part III

WORKING WITH YOUTH AT RISK: BEHAVIORAL ISSUES AND INTERVENTIONS

Chapter 8

THE SECRET AND ALL-CONSUMING OBSESSIONS: ANOREXIA NERVOSA AND BULIMIA NERVOSA

Frances A. Kempley and Wanda L. Weber

All four members of the eating disorders group are sitting in a circle waiting for Dr. Jones to arrive. The group includes three female adolescents and one male adolescent. John is on the wrestling team and looks like the picture of health. Mary, whose weight is normal, is a very attractive cheerleader. Teresa is a gymnast. She is well groomed but extremely thin. Jane is an honors student who wears several layers of loose clothing to disguise her emaciated appearance.

Although the group is small, the members are conscientious and attend each meeting. Although regular attendance is not always the case in eating disorders groups, these members were carefully chosen by Dr. Jones. They are all receiving other forms of counseling in addition to the group. The group is special to these members because it is the one place in which they can share their feelings about food and about themselves with their peers and not feel abnormal. Dr. Jones enters the room and the group begins.

Dr. Jones: "Does anyone want to begin our session with some current concerns?"

Jane, typically not as vocal as the others, speaks first.

Jane: "Ever since I was released from the hospital and returned to school, I notice other students staring at me in the halls and in the cafeteria. It's really bothering me."

Dr. Jones: "Have you come to any conclusions as to why people are staring at you?"

Jane: "I think it's because I've gained so much weight and everyone thinks I'm fat. I know that *I* think I'm fat."

Dr. Jones: "Sometimes how we feel and what is in fact true are very different. I understand that you feel fat right now and that this feeling is real to you, but I wonder whether others see you as fat. Would you like to get some feedback about your appearance from the other group members?"

Jane: "Yes, I would, although I don't know if I will believe them."

John: "People stare at you because you're so thin, not because you're fat."

Mary: "I agree that you are too thin. You really look very fragile. But I'm not too thin, and sometimes I feel like people are staring at me, too, in the cafeteria."

Dr. Jones (to Mary): "When you feel self-conscious in the cafeteria, what are you thinking about?"

Mary: "I'm wondering whether the others know that I binge. I never do it at school because there are too many people in the bathroom and I won't be able to purge. I do know other girls who don't seem to care if they are found out, but I do. I would die if anyone in my classes knew about my problem."

Dr. Jones: "Does anyone else feel like Mary—self-conscious when you eat and afraid that others will find out that you have an eating disorder?"

Teresa: "I do. I never feel comfortable eating in front of anyone. I try to eat salads when I'm around other people so they won't know how I 'pig out.' People would never guess from my size how much I put away. I usually binge and purge when I'm alone, but sometimes I do it around my family and that drives them crazy."

Mary: "I always start each day with a promise to stay on a diet. I try to stay away from food so that I won't binge, but when I get home from school, I just lose control."

Jane: "I have never binged and have always been able to diet. People told me how much they envied my control. I felt kind of special. And now people are telling me that I need to eat. It's easier to stay away from food altogether. I'm afraid that now that I've gained 5 pounds I'll just keep gaining. I'm terrified and feel out of control."

John: "I get terrified too. I'm afraid I'll get fat again if I don't purge. When I was a kid, I got teased a lot and was never picked to be on any teams. I never want to be rejected again."

Dr. Jones: "It sounds like all of you are afraid of losing control of your weight and of your eating. Do you ever feel afraid of being out of control in other areas?"

Teresa: "I feel totally out of control all the time except right after I binge and purge. The binging and purging gives me a kind of peace of mind for a little while until I start feeling rotten again. The bad feelings always seem to creep back."

Dr. Jones (to Teresa): "Can you describe some of these bad feelings?"

Teresa: "Before I began counseling, I couldn't even identify the feelings, but I'm gradually becoming aware that I'm sometimes disappointed and angry with my family."

Dr. Jones: "Are you aware of what disappoints and angers you the most?"

Teresa: "My parents are always fighting with each other despite the fact that they pretend to be happy outside the house. The only thing they agree on is that they want me to stop binging and purging. I make them look bad and spoil their image."

Jane: "My family never argues. Actually I'm not sure what any of them feel or what I feel. I do think they've given me a lot more attention since I've been sick."

Dr. Jones (to Jane): "It sounds like you have gotten praise in the past for your dieting and are now getting more attention from your family because of your eating disorder. Do you see any negatives to the way you've been living?"

Jane: "Yes, I do. I feel lonely and out of place with the kids at school. I'd like to socialize more but I'm afraid. I never have any fun. All I do is worry about my grades and about food."

Mary: "I can understand some of Jane's feelings. Even though people think I'm really outgoing, actually I'm afraid that people won't like me. I feel like the only reason anyone likes me is because I look attractive."

Dr. Jones (to Mary): "What gives you that impression?"

Mary: "People are always complimenting me on my looks. No one notices the other things I do. When I'm around other people all I think about is food."

Dr. Jones (to Mary): "Do you see any connections between the fears you have around other people and your constant thoughts of food?"

Mary: "I notice that when I'm doing something I like, I don't think about food as much."

Teresa: "Well, I love gymnastics but after each meet I binge like crazy."

Dr. Jones (to Teresa): "When you compete, are you feeling anxious or fearful about anything?"

Teresa: "Well, I am terrified of losing. The only attention I get is from being a good athlete."

Dr. Jones: "It sounds like each of you is fearful of being rejected by your peers and family. It also sounds like you have high expectations of yourself. It might be helpful to consider how you can value yourself even when others don't value you and how you can have reasonable expectations of yourself."

Although the previous dialogue covers just a small sample of concerns that individuals with eating disorders express, it touches on several important components that combine to create dysfunctional eating attitudes and behaviors. Many eating-disordered individuals do not seek treatment until adulthood, yet most eating disorders begin during the stressful years of adolescence. Although most adolescents share some of the same concerns individuals with eating disorders feel, their concerns are not as extreme and do not dominate their lives. What begins as an attempt to control weight becomes transformed into a way of life that short-circuits normative development—physically, socially, and psychologically. By the time many are either brought to treatment or seek treatment for themselves, they lag behind their peers in development. It is crucial that treatment be implemented before the behavior patterns become too infused. A recognition of the early signs and symptoms of an eating disorder in vulnerable adolescents can be a critical part of successful therapeutic intervention.

Although anorexics and bulimics may be men, the majority of eating-disordered individuals are women; therefore, this chapter will address anorexia nervosa and bulimia nervosa as female disorders. The chapter will discuss relevant sociocultural factors that set the stage for vulnerable adolescents to respond to both internal and external stressors by developing an eating disorder. The discussion will detail signs and symptoms that can alert teachers, coaches, family, and friends that a peer or student may be progressing to an eating disorder, and will then present the current theories of causation of the disorders. The chapter will continue with a review of types of treatment for anorexia nervosa and bulimia nervosa that include various counseling approaches that have effectively interrupted the eating disorder cycle, and will conclude with a consideration of prevention programs that may be employed by individuals, schools, or communities to dissuade the continuing development of eating disorders.

Sociocultural Milieu

Why have eating disorders become so prevalent in our society? One answer can be found in the national obsession with thinness. Magazines, newspapers, television, and even the fashion industry flash the covert and overt message that one must have a svelte figure in order to be successful, desirable, or even acceptable. Conversely, the cultural milieu deprecates obesity to such an extent that obese individuals are stigmatized and shunned. Historically, when food was scarce, obestity became associated with the upper social classes. As food has become more available, obesity has become associated with lower social classes and is seen as socially and physically undesirable.

Wooley and Wooley (1979) believe that the pursuit of thinness has become a moral issue. They report numerous studies showing that individuals are enculturated with this prejudice during childhood. Thinner children tend to be liked more than children of average or heavier weight. Weight was found to be critical in the relationship between body image and self-concept. The thinner the girl, the more likely she was to report feeling attractive, popular, and successful academically. Obese children were described as being ugly, stupid, mean, sloppy, lazy, and dirty based on their size alone, and were avoided more than children who were severely handicapped. They were seen as responsible for their condition.

The desirability of thinness coupled with the fear of and stigma toward obesity has lead to an increased interest in dieting. Over the past 20 years, magazine articles on dieting have increased significantly (Garner, Garfinkel, Schwartz, & Thompson, 1980). Among adolescents and young women, dieting is more prevalent that not dieting (Polivy & Herman, 1987). Dieters may use appropriate weight control strategies, but several researchers (Klesges, Mizes, & Klesges, 1987) found that even in a normal population sample, individuals frequently risked their physical health to attain thinness. Inappropriate weight loss methods used included self-induced vomiting, laxatives, fasting, over-the-counter appetite suppressants, smoking, and caffeine. Despite the current national emphasis on health and fitness, the quest for thinness overrides concerns for good health.

Why are so many more women affected by eating disorders than men? The societal pressure to be thin seems to affect the majority of women in a negative way. Leon, Carroll, Chernyk, and Finn (1985) found body size dissatisfaction to be significantly greater for women than for men. Of the women surveyed, 79.9% desired a lower body weight, whereas of the men surveyed, 65.1% were satisfied with their present weight or had an ideal weight that was higher than their present weight. These findings were confirmed by Fallon and Rozin (1985). They found that women view themselves as significantly heavier than their ideal and what they believed men would find attractive. For men, there were no significant differences between current weight, ideal weight, and the weight they perceived to be attractive to women. Women were also more likely to weigh themselves and to diet more frequently than men.

How has a preference for thinner female bodies evolved? The thin standard seems to be associated with wider issues regarding the role of women in society. Historically, the thin standard is correlated in a negative and significant way to the proportion of professional working women and to the proportion of women graduating from college (Silverstein, Perdue, Peterson, Vogel, & Fantini, 1986). Curvaceous women are seen as less competent and less intelligent. More ample bodies seem to be associated with the traditional feminine role of wife and mother. During periods when it is important for women to be seen as competent and intelligent, the standard of attractiveness demands thinness. In fact, Silverstein et al. reported that as women's concerns with what others think of their intelligence increases, their thin standard becomes even thinner.

Within a relatively short period of time, mental health professionals have observed high numbers of women reporting eating disorders. Several authors (Anderson, 1985; Casper, 1983; & Russell, 1985) believe that the high prevalence of symptoms of eating disorders is due to pathoplasticity, that is, the tendency for psychiatric disorders to change in response to changes in fashion. Because of the current emphasis on slimness and the high level of stress women experience in conflicting roles, they express their neurotic symptoms that otherwise may have come out in a different way as an eating disorder. Women who are susceptible to these forces are those who have been strongly influenced by societal pressures, who are perfectionistic, and who hold a self-schema in which body weight is central (Striegel-Moore, McAvay, & Rodin, 1986). Other women at risk include those who are biologically heavier, women who come from families that overemphasize appearance, and women who are depressed and ignore their own needs in preference to the needs of others.

Adolescence As a High-Risk Period for the Development of Eating Disorders

During adolescence several developmental tasks that link behavior with internal and external forces must be accomplished for satisfactory growth to occur. Developmental tasks are determined by the interplay of biological, cultural, and psychological forces. Strober and Yager (1985) listed four adolescent tasks necessary for optimal physical and psychological health: (1) adolescents need to establish peer attachments as part of the initiation of physical and sexual maturity; (2) they must progress from concrete to more abstract thinking, which is reflected in their ability to separate self from environment; (they develop a sense of the future by being able to separate from the here and now); (3) they must develop autonomy as expressed by shifting away from parental values and finding gratification outside of the home; and (4) subsequently, they must emerge with an identity and stable self-structure and a commitment to a system of personal beliefs.

The process of accomplishing developmental tasks includes discontinuities that are predictive of psychological health. Previously compliant children may become complaining adolescents. Their expressions of self-confidence may give way to expressions of self-doubt. As they express their desire for independence, they vent more feelings of dependency. Their tempers may become more explosive and unpredictable, yet such roller-coaster emotions are a normal and necessary part of adolescent growth. Eating-disordered adolescents fear such emotional upheavals and strive to counteract them by denial of feelings or increased efforts to be controlled and contained.

Physical maturation is another developmental factor affecting adolescents' vulnerability to eating disorders. Streigel-Moore et al. (1986) believe that the normal maturation process is a risk factor for girls. Physical maturity brings boys closer to the attainment of their ideal, tall, muscular look, but physical maturity in girls leads them to concerns about weight. Pubescent girls gain twice as much fat as boys. Adolescent girls list weight as their primary appearance concern, thus diets become a major focus. Adolescent girls seem to be more sensitive to evaluations by others and subsequently more sensitive to social demands. They receive a strong social message that beauty and thinness are important attainments. The authors report several studies showing that heterosexual relationships are more problematic for girls than boys, yet girls rank popularity as their first priority, even above independence or competence. In adolescence, when establishing heterosexual relationships is a primary task, thinness becomes synonymous with attractiveness and attractiveness synonymous with popularity.

Researchers have correlated several other factors that make some women more susceptible to developing eating disorders. Gross and Rosen (1988) found that depression, poor body image, and social anxiety predict eating disorders. Kiemle, Slade, and Dewey (1987) reported that general dissatisfaction, loss of control, perfectionism, high food avoidance, and preoccupation with weight were eating disorder correlates. Streigel-Moore et al. (1986) listed five components corresponding to eating disorder vulnerability: (1) women who are perfectionistic; (2) women who incorporate a belief system in which weight is central; (3) women whose families have high expectations and overemphasize appearance; (4) women who have a biological tendency to be heavier than they desire; and (5) depressed women with low self-esteem. Kaplan, Busner, and Pollack (1988) found that lack of satisfaction with appearance was associated with depression regardless of actual weight. Women who believed they were of normal weight were less depressed. Frequent dieting is invariably a precursor to the development of an eating disorder.

A developmental lag in several areas can be the disruptive consequence of an eating disorder. The greatest factor hampering normal adolescent development for both bulimics and anorexics is their social isolation. Social distancing creates poor peer relations, leaving little chance for discovering new ways of interacting. Peer groups are vital in the transition from adolescence to adulthood. They provide necessary links from the family to occupational and other nonfamilial spheres. Social impairment may cause problems at work and school as well as family disruption, and may exacerbate depression and anxiety, possibly leading to suicide attempts.

When an eating disorder is used as a coping mechanism, it increases both depression and stress and inhibits the learning of more appropriate coping skills. For example, female purgers are more likely than nonpurgers to abuse alcohol. They use alcohol as a stress reducer (Killen, Taylor, Telch, Saylor, Maron, & Robinson, 1987). The interpersonal deficits and lack of coping skills that result from eating disorders leave the adolescent unprepared for the later demands of adulthood.

Diagnostic Criteria

Anorexia nervosa is a syndrome characterized by the denial of hunger, a fear of fat, and diligent pursuit of thinness. Anorexia nervosa literally means "nervous lack of appetite;" however, a loss of appetite does not generally occur until late in the starvation process. The essential features of anorexia nervosa, commonly referred to as anorexia, as established by the American Psychiatric Association (1987) are:

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.
D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary

> amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) (p. 67)

Bulimia is the term most commonly used to refer to an abnormal weight control method that is characterized by episodic binge eating followed by a purging activity. The word bulimia literally means "ox hunger" or an insatiable craving for food, so the term bulimia nervosa more appropriately describes the binge/purge eating behavior. In 1987, the American Psychiatric Association amended the name of the syndrome of bulimia to bulimia nervosa. The revised criteria for diagnosing bulimia nervosa are:

> A. Recurrent episodes of binge eating with a rapid consumption of a large amount of food in a discrete period of time.
> B. A feeling of lack of control over eating behavior during eating binges.
> C. The person regularly engages in either self-induced vomiting, the use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
> D. A minimum average of two binge eating episodes a week for at least three months.
> E. Persistent over-concern with body shape and weight. (pp. 68-69)

Signs, Symptoms, and Theories of Causation

Anorexia Nervosa

Ninety-five percent of anorexics are female. The symptoms most often begin at either age 14 or age 18. It is currently estimated that between .6% and 1% of young women will suffer from anorexia. A first symptom is often a change in personality characterized by mood swings and social distancing. As a noticeable weight loss occurs, the anorexic no longer eats with family or friends but is always ready with numerous excuses such as "I already ate" or "I have other lunch or dinner plans." As the body weight drops lower, the anorexic is always cold and will often wear winter clothes near the summer months. The anorexic becomes more isolated as the disease progresses. The schedule of obsessive exercise and restraint of eating becomes a full-time job, leaving little or no time or energy for other activities. Sleep problems arise and by this time, menstruation will have ceased and the anorexic may be losing scalp hair. As the anorexic becomes more emaciated looking, peers may label her anorexic, which leads her to other manipulative behaviors. The anorexic feels angry toward others who chastise her or attempt to get her to eat, and she lies and deceives others about her eating behaviors.

As the self-imposed starvation continues, many of the recognizable symptoms include poor concentration, concrete thinking, rigidity, social withdrawal, anxiety, depression, and emotional lability (Garner & Bemis, 1982). In summary, the general symptoms of anorexia include low self-esteem, lack of self-confidence, inability to make decisions, perfectionism, dependency on others, compulsive overachievement, isolation, poor social relations, and emotional immaturity. (See Table 1 for a detailed list of the signs and symptoms.)

Environmental stressors, depression, and puberty are three common precipitating factors in the dynamics of anorexia that correspond with dieting. The anorexic begins her pursuit of thinness with dieting like many typical adolescents. Eventually, however, losing weight represents virtue, control, and mastery. Often the anorexic may have been slightly overweight before her self-imposed starvation. Environmental stressors such as family illness, the divorce of parents, or relocating cause anxieties. The potential anorexic reduces anxiety by dieting. Major life changes may also include losses such as the death of a loved one or a breakup with a boyfriend. Such losses may lead to depression, a possible increase in weight, and the beginning of a dieting obsession. Dieting is often begun in an effort to dissuade the growth of the breasts and hips during puberty.

The etiology of anorexia nervosa is unknown, but several theories have been formulated to explain the causation of this disorder. From a psychological view, it is postulated that the illness may act as a defense against anxiety regarding guilt over impulses. The anorexic feels virtuous and in control when she has the willpower to overcome her hunger instinct. The illness may serve to attract attention from her parents. When faced with increased stress, the anorexic's ability to control her weight loss provides a sense of stability. Bruch (1982) suggested that certain people are predisposed to anorexia because of basic ego deficits.

Other etiological viewpoints include developmental, sociocultural and learning, family, and biological theories. Developmental theory postulates that anorexia is a coping response to feeling overwhelmed by maturational crises. Anorexics may fear and wish to avoid anxiety-producing adult activities and relationships. Socioculturally, thinness is the standard of beauty that provides initial positive reinforcement for the anorexics' initial weight loss. Others may compliment them and ask for their dieting success secrets. Later, as they reach an emaciated state, attention and concern from parents and friends may be positively reinforcing. Positive self-reinforcement for self-control and weight loss may

TABLE 1

Signs and Symptoms of Anorexia Nervosa

Psychological

Poor self-esteem
Suicidal thoughts
Distorted body image
Compliance
Perfectionism
Rigidity
Fear of food and weight gain
Depression
Denial of problem
Overachieving
Anxiety
Feelings of control over body
Apathy
Mood swings

Behavioral

Extreme physical activity
Fatigue
Fights with family
Self-isolation from family and friends
Compulsive exercise
Overuse of laxatives or diuretics
Eating alone
Overeating (may cook and control family's eating)
Progressive preoccupation with food and eating
Sleep disturbances

Physical

Excessive weight loss—15% or more of total body weight
Malnutrition
Sensitivity to Cold
Diminished capacity to think
Cardiac arrest
Lassitude (fatigue)
Cavities and gum disease
Growth of facial and body hair (lanugo)
Hair, skin, and nail problems
Misperception of hunger, satiety, and other bodily sensations
Electrolyte imbalance (weakness)
Joint pain (difficulty walking and sitting)

perpetuate the behavior. As the anorexic develops the fear of food and fat, negative reinforcement of avoidance of feared situations contributes to the maintenance of the system (Garner & Bemis, 1982). Family theories deduce that the identified patient is an expression of an ill family. Families are generally studied after the diagnosis of the disorder, so the concurrent family dynamics may not necessarily reflect the premorbid conditions. Biologically, anorexia can be explained as being a hypothalamic disorder. Many researchers conclude that the anorexia syndrome is a consequence of the interaction of individual, familial, and cultural forces. Extensive research is still needed for the evidence of any one theory to be conclusive.

Bulimia Nervosa

Ninety percent of bulimics are female. The American Psychiatric Association (1987) lists the prevalence and sex ratios at 4.5% for women and .4% for men. Crowther, Post, and Zaynor (1985) found the incidence of bulimia to be as high as 5% in high school students. Self-report surveys of nonclinical college women engaging in binge eating range from 13% to 67% (Halmi, Falk, & Schwartz, 1981). The onset of bulimia generally occurs in late adolescence or early adulthood.

The initial symptoms of bulimia are occasional binge eating in response to feelings of deprivation due to strict dieting. After attempting to maintain a rigid diet for long periods of time, the bulimic will begin binging more frequently. Eventually, the fear of gaining weight leads the bulimic to engage in some form of purging. The average delay between onset of binging behavior and onset of purging behavior is 1 year. Once purging behavior begins, the frequency of binging increases. What began as an occasional weight loss technique becomes a daily occurrence. Most bulimics attempt to avoid food during the day. This avoidance causes mounting hunger, which ultimately results in a binge. The average bulimic binges on a daily basis at home in the later afternoon and early evening. As the disorder progresses, many do not eat regular meals at all and alternate between restricting or binging. They often plan their schedules around times when they can binge and avoid activities that prevent them from binging. They also avoid eating situations where they are unable to purge. Due to fluctuating blood sugar levels, bulimic women have difficulty concentrating and have wide mood swings.

The general symptoms for bulimia include low self-esteem, sensitivity to depression, poor impulse control, lack of assertiveness, cognitive distortions, poor body image, and the use of binges to deal with stress. (See Table 2 for a detailed list of the signs and symptoms.)

The onset of bulimic symptoms is most often associated with a period of voluntary dieting, difficulty in handling negative emotions, and traumatic life events such as a loss or transition. Developmentally, bulimics have difficulty dealing with transitions and changes. Common major life events affecting bulimics are interpersonal losses such as breaking up with a boyfriend or the death of a parent, and transitional events such as moving away from home to a university or changing a job. Strober (1984) found that stressful events most often reported by bulimics included estrangement from friends, marital discord, conflict with parents, serious illness in a parent or self, involvement with drugs,

TABLE 2

Signs and Symptoms of Bulimia Nervosa

Psychological

Low self-esteem
Embarrassment
Anxiety
Depression
Mood swings
Feeling that self-worth depends on low weight
Dependency on others for approval
Constant concern with weight and body image
Fear of binging/eating and getting out of control
Suicidal tendencies/attempts

Behavioral

Poor impulse control
Self-indulgent behvior
Eating alone
Dishonesty—lying
Stealing food/money
Drug and alcohol abuse
Experimentation with vomiting, laxatives, and diuretics
Preoccupation with food and eating
Elimination of normal activities
Social isolation/distancing from family and friends
Binging on high carbohydrate foods
Laxative and diuretic abuse

Physical

Normal weight
Anemia
Tooth damage
Chronic sore throat
Electrolyte imbalance
Dehydration
Irregular heart rhythms
Tiredness, apathy, irritability
Gastrointestinal disorders
Difficulties in breathing/swallowing
Hypokalemia (abnormally low potassium concentration)
Generally ill health/constant physical problems
Possible rupture of heart or esophagus/peritonitis

increased absence of father from the home, and disillusionment with school.

Many theories of etiology have been postulated to explain the pathogenesis of the bulimic syndrome. A theory of etiology developed by Johnson and Maddi (1986) includes psychological, biological, sociocultural, and family factors. This model must be considered as a tentative explanation of the syndrome because empirical validation is still needed.

From a psychological perspective, the bulimic has a vulnerable personality with affective instability. This instability is evidenced by impulsive behaviors and low frustration tolerance, low moods, high anxiety, and highly variable moods. The bulimic has low self-esteem, is self-critical and interpersonally sensitive, has a high need for achievement, feels ineffective, and has a high level of dissatisfaction for her body. From a biological viewpoint, the bulimic may have an increased risk for depression that is genetically transmitted. Several family studies (Hudson, Laffer, & Pope, 1982) report a high prevalence (48%) of familial affective disorder in the first-degree relatives of bulimic patients, similar in prevalence to families of patients with affective disorder. Although the etiology of depressive symptoms remains unclear, it does seem that bulimics have a high risk factor for developing an affective disorder. Bulimics may also have a biologically higher "normal" weight or set point. Their set point may be aesthetically too high for them but physiologically normal. Such individuals may begin to diet in an effort to control their body dissatisfaction. The dieting then leaves them chronically hungry, setting the stage for binging.

Sociocultural factors relevant to causation include both changing sex-role expectations and the emphasis on appearance. Because cultural norms are in transition, women face ambiguous and contradictory role expectations. The new wider range of possible role choices may be overwhelming for field-dependent individuals who lack internal structure. The bulimic may experience much anxiety in reaction to shifting role expectations in light of the high demand for achievement from her family. Combined with the feminist movement, the pursuit of thinness has emerged as one way women can compete and demonstrate self-control. Thinness is highly valued, and pursuing it becomes one concrete activity through which women can compete.

Family factors include a familial environment often characterized as disengaged, chaotic, and highly conflicted with a high degree of stress. Family members use indirect and contradictory communication patterns. The families have high achievement expectations yet have limited intellectual and recreational orientations. In summary, these etiological theories generally agree that individual personality deficits combined with family and cultural factors serve to direct the individual's anxiety onto her body.

Bulimia and Anorexia Compared

Bulimia and anorexia have several similarities but also important differences. The disorders may be viewed on a continuum with overlapping symptoms along the spectrum. Not all individuals experience every symptom nor do the symptoms progress in exactly the same order for every bulimic and anorexic. Shared features of the two disorders include a fear of fatness, a preoccupation with weight and food, and the use of weight and food to cope with emotions. There are several differences between anorexics and bulimics. Anorexics tend to be more introverted and less sexually active than bulimics. The amount of weight lost is usually much greater for anorexics. Whereas anorexics have few behavioral abnormalities, bulimics often engage in impulse behaviors such as stealing and drug and alcohol abuse. The restrictive eating behavior of anorexics is usually a source of pride and self-esteem. On the other hand, bulimics' eating behavior is often ego dystonic and a source of stress and shame. When an anorexic becomes bulimic, she will manifest both anorexic and bulimic symptoms; however, treatment goals and the recovery process are comparable for both eating disorders.

Treatment Applications

Anorexia Nervosa

Impediments to Treatment

Anorexics generally do not recognize that their disorder is dysfunctional and is disrupting their lives. They have derived feelings of competence and uniqueness from being able to diet successfully and maintain control despite the intense hunger they often feel. Therapy is viewed as a threat to their self-esteem. They fear being robbed of their specialness (Anderson, 1985) and being asked to relinquish their dieting behavior, which has become a way of life that solves life's complexities. Often their families share the anorexics' high regard for the value of thinness and subtly ignore the severity of their childrens' problem.

Anorexic families frequently present a healthy image to the outside world and discourage much intimate contact with others, viewing such contact as an invasion of their autonomy and closeness between family members. They may view therapy or any expression of feelings as a sign of weakness, so they avoid treatment. Some families avoid help because they fear it will only escalate the existing family problems. Consequently, treatment is often delayed to the point where normal development has been impaired.

Types of Treatment

Medical consultation and assessment. A medical assessment of the anorexic's status is essential because of the severe medical problems related to starvation and malnutrition. The individuals' vital signs are often lowered including blood pressure, heart rate, body temperature, and respiration rate (Anderson, 1985). A physical exam and laboratory evaluation are necessary to confirm that no other illness has caused the weight loss and to assess the severity of the malnutrition. At a minimum, the individual should have a test battery that includes a blood test, electrolyte test, liver and thyroid functioning tests, an electrocardiogram, and a chest X ray (Brotman, Rigotti, & Herzog, 1985). In severly emaciated individuals, weight and vital signs need to be monitored regularly.

Nutritional rehabilitation. Nutritional rehabilitation is the first step in any treatment program whether done alone or on an inpatient or outpatient basis. Starvation affects cognitive and affective functioning in addition to physical capacities. Mental efficiency is decreased. Driven activity may disguise low mood and intrusive thoughts of food. The individual may appear somewhat suspicious and fearful. Garner (1985) stated:

> The failure to differentiate primary psychotherapy from the secondary elaboration of starvation symptoms not only leads to a faulty conceptualization of dynamic issues but also disregards the observation that psychological themes at presentation may share little with those which emerge at weight restoration. (p. 703)

Although the restoration of body weight may seem intrusive to the individual, it is necessary for the perservation of thinking and to increase abstract thought. In addition, as weight increases, the resultant change in hormonal balance tends to increase affective reactions that are not apparent during the starvation state.

Although the method of weight restoration used depends on the severity of the illness, it is best to use the least restrictive approach (Neuman & Halvorson, 1983). If the illness is in its early stages and hospitalization is not needed, consultation with a dietitian is helpful. The individual should be provided didactic material related to starvation, weight regulation, and nutrition. Then a realistic target weight is established. Some programs set the minimum target weight as the weight at which menses return plus five pounds. The weight selected should be consistent with the individual's weight history. Weight must be monitored regularly with attention to a weight loss that may require hospitalization. Often the initial goal is weight maintenance, then after a week, a weight gain of one to two pounds per week is advised (Strober & Yager, 1985). In outpatient treatment, weight gains may be flexible but must be sustained. The individual also is helped with meal planning. The outpatient therapist or dietitian should help minimize food choices for the individual. The therapist may have to focus on details of food intake as part of the therapy process. Eventually feared foods will have to be incorporated into the diet.

Food is presented to the individual as prescribed medication and meals are supervised. Most inpatient programs (Anderson, 1985; Strober & Yager, 1985) encourage patients to regain weight by eating normal meals on a regular basis. This process of relearning how to eat in a normal way is time-consuming but important to overcoming the fear of food. The individual must be reassured she will not get fat and weight gain will not be excessive or rapid.

Inpatient treatment. Several indicators point to the need for inpatient treatment. Individuals who are at a significantly low weight (25% below normal weight) do not do well in outpatient treatment because chronic hunger interferes with mental functioning. As hunger increases, so do intrusive thoughts of food and anxiety caused by the urge to eat. Another indicator for hospitalization is metabolic abnormalities such as low levels of serum potassium caused by purging. Low mood is an indicator of inpatient care, especially when the individual has suicidal ideations or intents. Individuals who have not improved after much outpatient treatment and individuals whose families are demoralized and are no longer willing to help are also appropriate for inpatient treatment. If at all possible, the anorexic individual should be involved in making the decision for hospital admittance. Sometimes admission needs to be negotiated between the patient and the family (Powers & Powers, 1984) and sometimes, if the individual is very ill and refuses treatment, a court order may be necessary to prevent self-harm (Anderson, 1985).

A highly structured environment at the beginning of treatment seems to be helpful. Initially, such a structure helps to decrease anxiety and the fear of losing control. Inpatient programs frequently use contingency management programs as well as a standardized behavioral contract for weight restoration (Vandereycken, 1987). The individual who gains weight is positively reinforced by receiving privileges and increased freedom whereas the individual who does not gain weight is denied access to the reinforcing activities. An emphasis on immediate weight gain may be necessary for severely emaciated or resistant individuals. Although attention to weight does produce positive short-term results, the long-term results may be further interpersonal or intrapsychic difficulties. Garner (1985) warned that behavior modification principles must be used with a focus on the individual. Weight gain and eating should not be the exclusive focus of attention.

Inpatient programs generally include multiple forms of treatment including individual, group, and family therapy. Often they also include other hospital therapies such as art and movement therapy, leisure counseling, and assertiveness and relaxation training. Strober and Yager

(1985) and Vandereycken (1987) believe that anorexic adolescents should be exposed to nonanorexic patients. They agree that anorexics can use others as models to learn coping skills. It is extremely important to prepare the individual for discharge and provide adequate aftercare to prevent relapse.

Outpatient treatment. Outpatient treatment is suitable for individuals who express motivation to change, have some insight, and are able to tolerate some weight gain. Individuals who are not more than 20% below ideal weight are also good candidates. They should not be severely depressed and should be able to maintain some peer relationships (Strober & Yager, 1985). Also, individuals who have been discharged from inpatient treatment require outpatient treatment.

The goal for younger patients who have not been chronically ill is to achieve normal weight and to reintegrate into their normal life. Outpatient treatment follows the same principles as inpatient treatment except that the stages of nutritional rehabilitation and psychotherapy overlap more. Psychotherapy begins sooner because the individual is not as physically compromised as an inpatient counterpart. Although a meal plan may be compiled by a nutritionist, often the therapist monitors progress in weight gain and eating. Therapy must include a focus on eating patterns and their relation to emotions and behavior. Gradually the patient assumes full control of choices regarding food, exercise, and weight. In outpatient treatment, it is important to help the individual structure free time. It is best to have a moderately paced and well-structured day.

Pharmacological treatment. Several medications have been utilized in the treatment of anorexia. Most have yielded disappointing results (Brotman et al., 1985). Because starvation affects mood, several authors do not prescribe antidepressants until the individual is within normal weight and symptoms of depression persist (Anderson, 1985; Garner, 1985). The most commonly used antidepressant medications for anorexia are the tricyclics and the monoamine oxidase inhibitors. Anti-anxiety medications are also used to reduce anticipatory anxiety prior to meals and can be useful for sleep disturbances. The abuse potential in restricting anorexics tends to be low, so anti-anxiety medication can be used with greater safety than with bulimics. Even when medication is helpful, it should not be the sole form of treatment because psychological and developmental issues still need attention.

Useful Counseling Approaches

Individual therapy. Individual therapy at first should be generally supportive to help the patient cope with interpersonal and intrapsychic difficulties. Individual therapy requires an especially trusting relationship between the therapist and patient because the patient wants to retain the symptoms. The goal of therapy is to decrease the symptoms while increasing personal growth. Insight-oriented therapy helps the anorexic in recognizing and differentiating internal physical and emotional states and in acknowledging and expressing affect. The individual is encouraged to take risks, increase a tolerance for uncertainty, and focus on issues of autonomy. The fear of losing control and the meaning of low weight must be explored.

Cognitive approaches are used to help challenge irrational thoughts regarding food and self. Therapy must correct these thoughts and provide alternative ways of viewing the self and the world. The anorexic must also develop a more accurate body image and so must challenge perceptual distortions. Behavioral approaches are used to increase coping skills such as assertiveness, relaxation, and social skills.

Family counseling. Anorexia can become a focal point for family interactions (Sargent, Liebman, & Silver, 1985). The anorexic is affected by the family and the family is affected by the eating disorder. Several researchers (Anderson, 1985; Sargent et al., 1985; & Strober & Yager, 1985) believe that family therapy is a necessary part of treatment unless the family is extremely hostile or intrusive.

The goals of family counseling are to help each member deal with concerns about the eating disorder problem, become more autonomous, resolve conflict, and encourage appropriate coalitions between the family subsystems. The structural family therapists propose that anorexic family traits include enmeshment, overprotection, rigidity, lack of conflict resolution, and involvement of a child in parental conflict. The anorexic family has not promoted the autonomy of its members. The family must be encouraged to reinforce the independent action of its members and to encourage the anorexic to build salient connections with her peer group instead of being bound to the family. The specific goals in therapy may depend on the stage of the family life cycle. If the anorexic is very young and will be living at home for a long time, treatment strategy will be different from that for an older child.

Vandereycken (1987) does not assume that all eating disordered families are dysfunctional, but does agree with other researchers that the family is in crisis and could benefit from intervention. Families must be viewed as treatment resources and not treatment adversaries. There may be typical types of families, but there is also much diversity. The family therapist needs to assess patterns in the family that may be sustaining the anorectic behavior.

Group therapy. Group therapy is an important adjunct to individual and family therapy for anorexic individuals. It provides an opportunity to work on peer relationships, to explore feelings about family, and to increase self-awareness and self-expression. Reestablishing close peer relationships is integral in the treatment of anorexia. Group feedback greatly affects the anorexic's perceptual distortions (Inbody & Ellis, 1985) and cognitive distortions (Strober & Yager, 1985). Group therapy is often not used with anorectic individuals because their personality dynamics tend to make them poor candidates for group therapy. They are usually withdrawn, rigid, egocentric, anxious, and have difficulty with identifying and expressing feelings. Hall (1985) stated that members must be carefully selected. She suggests that the two counterindicators for group inclusion are denial of the illness and need for medical management of starvation symptoms. The group goal must be safe and allow individual attention to each member's feelings. The therapist often must be very active and provide much structure in the beginning stage of the group. Groups are an ideal environment for anorexics to explore lack of assertiveness, fear of displeasing others, and feelings of anger and isolation.

Bulimia Nervosa

Impediments to Treatment

In contrast to anorexic individuals, bulimic individuals generally do recognize that their eating habits are abnormal and have a disruptive influence on their lives. Although they may want to change some of their behaviors, they are also extremely fearful of giving them up. Most bulimics believe that they can maintain a desirable weight only by binging and purging. If they consume normal amounts of food and do not purge, they fear they will be overweight. Many associate being overweight with social isolation and rejection by peers and family. Because they feel their only choice is to be either bulimic or overweight, many choose to remain bulimic because they can retain a socially acceptable outward appearance that connotes control. In addition, some bulimic individuals do recognize that the bulimic cycle helps contain and regulate their affective reactions. Because many do not have adequate coping skills, they fear living without the anxiety reduction that binging and purging afford.

Another impediment to treatment is the socially undesirable and repulsive nature of the behavior itself. Many bulimics fear rejection if their behavior were to be known, so they keep their behavior in the closet. These women are extremely sensitive to the rejection of others and fear being perceived as less than capable. Again, as in the case of anorexia, treatment often is not sought until the behavior has been occurring for some time.

Types of Treatment

Studies on the treatment of bulimia have been primarily undertaken only within the last decade; therefore, treatment conclusions are still rather tentative. Currently, however, a study of treatments by Laessle, Zoettl, and Pirke (1987) found that overall the average bulimic patient after treatment was better than 83% of the patients prior to treatment. These authors concluded that psychotherapy, especially when combined with dietary management, was superior to drug therapy.

Medical consultation and assessment. Medical complications can and do arise in the treatment of bulimia. The most predominant danger is electrolyte imbalance due to purging by vomiting or abusing laxatives and diuretics. Because electrolyte imbalances can be fatal, it is imperative that a medical assessment be done by a medical doctor prior to counseling. A medical evaluation includes an assessment of gastrointestinal symptoms, weight, and hypokalemia and its medical consequences. If the individual is using laxatives to purge, it is advisable to have a physician monitor the individual to decrease laxative dependency. Electrolytes should also be monitored during treatment.

Nutritional rehabilitation. Normalization of eating is usually given top priority in most treatment programs. Until a normal intake is reestablished, the bulimic will be compelled to binge due to biological cravings. Many bulimics maintain weight goals that are far below their own biological set point (Garner, 1985). Their desire for a low body weight causes them to constantly fight their own biology. Many treatment programs first help individuals determine an appropriate weight goal given their prior individual and family history. Many suggest nutritional counseling and meal planning with the help of a nutritionist (Rock & Yager, 1987). Some programs teach appropriate eating habits and the appropriate use of aerobic exercise to regulate energy balance. Most programs (Fairburn, 1985; Lacey, 1983) encourage individuals to introduce forbidden foods in their diet gradually. Many bulimics have eliminated whole categories of food, which also enhances their cravings for these forbidden foods. Only after an appropriate weight is reestablished and a full range of food is restored will bulimic individuals be able to focus on psychological reasons for binging and purging. Purely psychodynamic treatment approaches that do not attend to changes in eating behavior have not proven effective (Garner, 1985).

Inpatient treatment. Inpatient treatment generally is not the treatment of choice for bulimic women (Anderson, 1985; Russell, 1979;

Yager, 1985). These authors suggest that inpatient treatment should be considered only if medical complications exist that require treatment such as low body weight or electrolyte imbalances, if the patient is suicidal, of if outpatient therapy has failed and the patient's health is suffering. Anderson believes that inpatient therapy is not usually therapeutic for treating impulse disorders.

Many bulimic women are able to stop the bulimic cycle when hospitalized because they are under constant supervision and are insulated from the stresses in their daily lives. When discharged and left to their own devices, they are not able to continue their progress. Anderson (1985) stated that bulimics have even more difficulty than anorexics in making the transition from the hospital to their home environment. Bulimic inpatient treatment is usually not as comprehensive as anorexic inpatient treatment. Bulimic treatment includes initial normalization of eating, individual and group therapy, and often family therapy. When hospitalization is utilized, attention must be given to follow-up care because relapse is common.

Outpatient treatment. Initially, outpatient treatments focused on only the symptoms of binging and purging. Most researchers now believe that treatment needs to be multifaceted and attention needs to focus on the bulimic symptoms as well as other coexisting deficits (Orleans & Barnett, 1984). Behaviorists suggest that a complete functional analysis of the antecedents and consequences of bulimic behavior must be made before treatment is implemented. A complete functional analysis provides many points of intervention. Loro (1984) specified four areas of treatment intervention: cognitive, behavioral, emotional, and interpersonal. Among cognitive problems he listed lack of knowledge regarding food, distorted body image, and dichotomous thinking styles. Behavior problems include irregular eating and extreme dieting. Emotional problems involve a poorly developed capacity to define and express feelings effectively, including a confusion between negative feeling states and hunger. Interpersonal problems include nonassertiveness, isolation, counterdependency, and rebelliousness. Many interventions have been used successfully to treat these problem areas. They include cognitive restructuring, anxiety management, self-control techniques including self-monitoring, emotional expressiveness training, anger control, assertiveness, social skills training, and paradoxical techniques. Outpatient treatment programs run the gamut from highly structured, intensive abstinence-based programs (Pyle, Mitchell, Eckert, Hatsukami, & Goff, 1984) to weekend retreats (Bohanske & Lemburg, 1985).

Pharmacological treatment. Several researchers believe that bulimia may be a symptom of or be related to a primary affective disorder (Pope, Hudson, & Jonas, 1984). As a result, antidepressant medications have been used to treat bulimics. They include monoamine oxidase inhibitors (MAOIs) and tricyclic and tetracyclic antidepressants. Some researchers have reported that tricyclics are well tolerated by adolescents and that MAOIs are well tolerated by older, more chronic individuals with symptoms of atypical depression. Treatment studies utilizing antidepressant medications have found equivocal results (Garner, 1985). Mitchell (1988) stated that the effectiveness of antidepressants has not been definitively demonstrated either in the short run or the long run. Studies show high dropout rates and high relapse rates after medication has been discontinued. Walsh (1988) reported that antidepressants are superior to placebos and that a significant fraction of bulimics do respond to medications; however, it is not known how many who initially respond will continue to respond if they remain on medication and how many will relapse if medication is discontinued. Researchers do not know how to distinguish responders from nonresponders because some women who are severely depressed are not helped whereas some who seem to be mildly depressed may be helped. Researchers also do not know whether antidepressants affect an underlying depression or affect another mechanism of action.

Garner (1985) suggested caution in the use of medications. He believes the treatment should sequence from the least potentially harmful or intrusive to that posing greater risks. A trial of psychotherapy would seem to be less intrusive than medication and should be tried first. As with anorexia, he also suggested that because depression may be secondary to starvation, severe dieting, and electrolyte imbalance, it may be more appropriate to normalize weight and eating patterns prior to antidepressant therapy. He stated that the use of antidepressants results in many negatives including poor compliance, side effects, and risk of abuse. Walsh (1988) recommended that patients who have failed to respond to psychotherapy are good candidates for antidepressant treatment and Mitchell (1988) recommended medication where bulimia occurs secondarily to a depressive disorder. Many advocates of antidepressant medication also support the use of psychotherapy in addition to antidepressant therapy because ignoring psychosocial factors and attitudes about eating and body shape is counterproductive.

Useful Counseling Approaches

A wide variety of interventions have been utilized in the treatment of bulimia. Each method has received some support in the literature, but it is premature to state that any one type of treatment has proven efficacy over another (Yager, 1985). Treatments have been used with individuals, families, and groups.

Individual therapy. Individual treatments can be tailored to meet the idiosyncratic needs of the client and may be necessary with individuals who would not benefit from a group approach. Individual treatment generally includes some education regarding weight and eating behavior. A behavior focus may utilize self-monitoring to increase awareness of patterns and the teaching of alternative coping skills including relaxation and assertiveness. Bulimic individuals have cognitive distortions that not only affect their eating behavior but also their self-image and other attitudes. Cognitive restructuring is utilized to decrease such distortions (Garner, 1986). The counselor can not only help to challenge reasoning errors such as dichotomous thinking, personalization, and overgeneralization but also can challenge the individual's underlying assumptions. An underlying assumption might be that weight and shape are a valid frame of reference for judging one's self-worth. Individuals learn to recognize connections between their dysfunctional thoughts, behaviors, and feelings. They are taught to substitute more realistic interpretations. Individual therapy also focuses on insight and affective growth. Individuals are helped to cope with affect, increase their toleration of dysphoria, and work on unresolved or current grief and anger issues.

Family counseling. Although some researchers view family therapy as an essential part of treatment, especially with younger individuals, others view family therapy as one possible component in a multidimensional treatment program (Vandereycken, 1987). Although family therapy is not always required, it is necessary to maintain a family-oriented approach. This approach allows an awareness of the family system and the ways in which the eating disorder of an individual is affected by and affects the family system. Not all bulimic families are dysfunctional but they are in crisis (Vandereycken). Bulimic families vary, but several structural family therapists like Minuchin describe them as having the common traits of enmeshment, lack of conflict resolution, overprotection, rigidity, and involvement of the child in unresolved marital conflict. Schwartz, Barrett, and Saba (1985) also added that bulimic families are isolated, unduly conscious of appearances, and attach a special meaning to food and eating. White (1984) stated that overinvolvement of the family influences the bulimic member to suppress normal adolescent tendencies toward autonomy and independence. Bulimics often are fearful of displeasing their parents and relying on their own judgment.

Following this conception of family dynamics, the goals of family therapy are to strengthen boundaries between the various subsystems in the family in order to facilitate individuation of family members. Family members are helped to negotiate more appropriate behavior and communication patterns and rules between members. The bulimic member needs to be helped to take more direct control of significant relationships and decision making.

Group counseling. Group counseling has been increasingly utilized as an alternate or adjunct to individual therapy. It is cost-effective and can be therapeutically advantageous. Bulimic individuals are often isolated, so groups can provide needed support to help individuals cope with their feelings of shame, guilt, and fear (Stuber & Strober, 1987). Although peer support is helpful for all bulimic individuals, it is especially effective with adolescents to challenge the unhealthy sociocultural pressures that adolescents face regarding diets and thinness.

Groups are particularly effective to use in combating body image distortion. When individuals see how others distort, they can more readily understand their own distortions (Inbody & Ellis, 1985). Groups provide an opportunity for modeling new behaviors. Members can learn to take risks and attempt to use new behaviors within the safety of the group. They can risk sharing their feelings or being assertive. When group members are at similar developmental stages, the issues of identity development, sexuality, and familial conflicts can be readily explored.

The first group treatment for bulimics was done by Boskind-Lodahl and White in 1978. Since that time, both short-term and long-term groups have been used. Most of the short-term groups in the literature follow a structured format. In the first phase of treatment, didactic information and normalization of eating are stressed as is developing awareness of the connections between thoughts and feelings and eating. Later, cognitive restructuring, identification and expression of feeling, and goal setting are used. Members also focus on developing problem-solving and coping strategies including relaxation and assertiveness skills. Short-term groups can be effective (Johnson, Connors, & Stuckey, 1983; Wolchik, Weiss, & Katzman, 1986) and are especially appropriate for individuals who do not have a chronic or severe problem. Even with more chronic individuals, groups serve as an excellent complement to individual therapy. A drawback of groups is that the attrition rate is often much higher than it is in individual therapy. Dropouts tend to be younger and more isolated. They are less likely to be employed, married, or sexually active and are more likely to have a diagnosis of a personality disorder (Merrill, Mines, & Starkey, 1987).

Prevention

The prognosis for recovery from an eating disorder is far greater if treatment begins before the disorder becomes chronic (Kiemle et al., 1987). Early identification is imperative so that individuals can be treated before developmental delays become disabling.

Professionals who are in contact with adolescents at risk for developing eating disorders should be alert to possible clues. Although any one indicator may arouse suspicion, the professional should be aware of a combination of indicators over an extended period of time (Neuman & Halvorson, 1983). The first indicators may be a change in behavior or personality. Possible indicators of anorexia nervosa are sudden noticeable weight loss, isolation from peers, increase in exercise and activity level, denial of fatigue, excessive studying without improvement in grades, claiming to feel fat when under or normal weight, denial of hunger and chronic dieting, preoccupation with food and calories, mood fluctuations, and low self-esteem.

Possible indicators of bulimia nervosa are evidence of binge eating, chronic dieting, use of vomiting and laxatives, frequent trips to the bathroom after meals, irritability, mood fluctuations, and low self-esteem. Adolescents who are at high risk are those in the performing arts, gymnasts, wrestlers, cheerleaders, and track team members. Adolescents who are suspected of having an eating disorder should be approached gently and should be assessed. Professionals should be prepared to provide referrals to community therapists who specialize in eating disorders work.

Professionals also can participate in primary prevention by educating students, parents, and the public about eating disorders. Teachers and other professionals need to advocate healthy goals and attitudes and must help adolescents challenge some unhealthy cultural attitudes. Adolescents should have access to groups that teach coping skills such as assertiveness and stress management and should receive affective education to help them deal effectively with their feelings and enhance their self-esteem. Lastly, professionals should help reintegrate eating disordered adolescents into the mainstream after they have been ill. Support groups can help these individuals to readjust to life without an eating disorder.

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Chapter 9

FEMALE, SINGLE, AND PREGNANT: ADOLESCENT UNWED MOTHERS

Rosemary Thompson and Ardis Sherwood

Introduction

The incidence of pregnancy and the number of out-of-wedlock births to school-age adolescent girls are increasing at an alarming rate. There are 10 million women in the United States between the ages of 15 and 19, and each year, over 1.1 million of these young women become pregnant (Alan Guttmacher Institute, 1984; Children's Defense Fund, 1988). Every day, more than 3,000 adolescent women become pregnant, 2,300 of these pregnancies are unintentional, and 1,300 of these pregnancies result in live births (Edelman, 1987). Nearly three quarters of these pregnancies occur among unmarried teenage women (O'Connell & Rogers, 1984), and it is estimated that more than 90% of these adolescent mothers keep their babies (Ascher, 1985). Perhaps most disturbing are the data that reveal that 125,000 girls under age 15 become pregnant each year (Children's Defense Fund). Each day, 26 children between the ages of 13 and 14 will have their first baby, and thirteen 16-year-old girls will have their second child (Edelman, 1987).

Studies have indicated that the majority of sexually active teenagers do not want to become pregnant, and according to The Alan Guttmacher Institute (1981), 80% of all teenage pregnancies were unanticipated. Despite the fact that many adolescents are knowledgeable about how to obtain and use contraceptives, most teenagers do not practice contraception or, when they do, the methods are erratic and irregular (Alan Guttmacher Institute, 1981). A study of 134 sexually active adolescents revealed that only 22% of the women and 33% of the men reported ever having used contraceptive measures (Kyman, Berger, & Perez, 1987), and research conducted by The Alan Guttmacher Institute (1981) and Zabin et al. (1981) indicated that teenagers begin to seek birth control advice after they have been sexually active for 9 to 12 months. It is, therefore, not surprising that half of all first premarital pregnancies occur during the first 6 months of sexual activity (Alan Guttmacher Institute, 1981).

The statistics on teenage pregnancy do not summarize adolescent sexuality, but they do confirm that many adolescents initiate sexual activity during a developmental stage that is characterized by risk-taking behavior and a propensity to act without a full sense of the potential consequences of their actions.

Numerous studies over the past decade have indicated that one of the most profound trends among American adolescents is a significant increase in both pregnancy (Dryfoos & Heisler, 1978) and the subsequent rearing of offspring by single, school-age mothers (Ogg, 1976). The percentage of teenage pregnancy and childbirth is significantly higher in the United States than in any other industrialized nation (Brozan, 1985). This trend is becoming a national concern, and is considered by many to be an epidemic (Baizerman, Sheehan, Ellison, & Schlesinger, 1971; Braen & Forbush, 1975; Furstenburg, 1969; Klerman, 1975; Piotrow, 1975). A study by Ogg (1976) indicated that the number of one-parent families has increased seven times as rapidly as the number of traditional two-parent families, and a growing proportion of these single-parent families are represented by never-married teenagers. According to Nye (1976), school-age children between 14 and 16 years of age are the most rapidly increasing age group of single parents, and Moore and Caldwell (1977) estimated that "of all children born out of wedlock, at least 60% end up on welfare" (p. 164).

There is a pervasive need for programs that focus on personal functioning and offer comprehensive services that address the needs of unwed adolescent mothers, but parents, school administrators, counselors, and social agencies are frequently ambiguous about which methods and approaches should be taken to assist young mothers and their children. The dilemma is multidimensional, and involves many physical, psychological, educational, and socioeconomic issues. There are also numerous intervening and escalating variables (such as poverty and the lack of job entry skills) that contribute to the psychological distress of these young mothers. Essentially, there is a vital demand for adequate collective services, as well as for programs that would enhance the well-being and promote self-sufficiency in single teenage mothers, yet the potential change agents in the community remain elusive about who will take the responsibility for providing social support and services for this growing at-risk population.

Various research efforts have been conducted to identify factors associated with adolescent pregnancy. These studies indicate that, for a significant number of adolescents, certain antecedent events, influences, and interpersonal characteristics seem to be present before the onset of a teenage pregnancy. A very high proportion of young, pregnant, single mothers come from economically and socially deprived backgrounds (Children's Defense Fund, 1988). Research by Kaplan, Smith, and Pokorny (1979) suggests that these young women are likely to identify their families, schools, and peers as sources of self-devaluing experiences, and Michaels and Brown (1983) found that the choice for motherhood in teenagers is inversely related to having other sources of satisfaction. The literature also documents that various accompanying attendant conditions, influences, and personal characteristics emerge during the time of pregnancy. Early motherhood is associated with a significant reduction in education (Ireson, 1984; Moore & Waite, 1977), and Barth, Schinkle, and Maxwell (1983) concluded that adolescent pregnancy and childbearing contribute to a lowered self-esteem and a predisposition toward depression. Many proponents of adolescent health and well-being report a number of ominous concerns because of the potential social, psychological, and economic hardships of the adolescent mother. In addition, correlational studies have identified certain factors, such as socioeconomic status, that are beyond the scope of influence of any single public or private agency.

The fact that many adolescents are becoming parents before they finish high school is an educational and economic problem that policymakers, community members, and educators cannot afford to ignore. Inherently, the legacy of adolescent parents will be their own children who will, in turn, perpetuate the cycle of poverty and become the next generation of at-risk youth.

This chapter will provide an overview of precipitating variables and the long-range consequences of adolescent pregnancy. Potential interventions and a multimodal model for assisting adolescents will be discussed, and recommendations for preventing pregnancy through a shared commitment from public and private agencies will be provided.

Relevant Studies

Demographic Variables

Early parenthood and illegitimacy are associated with (a) lower education and occupational attainment (Edelman, 1988; La Rue & Miller, 1988; Ireson, 1984; Ventura, 1984); (b) marital instability (Moore, 1983);

(c) closer spacing of subsequent children and larger completed family size (Wilson, 1986), and (d) poorer mental and physical health of the mother and the child (Mecklenburg & Thompson, 1983; Millman & Hendershot, 1980). In addition, an absent father figure and greater number of siblings in the teenager's family correlate positively to the risk of adolescent pregnancy (Furstenburg, 1976; Goldfarb, Mumford, Schum, Smith, Flowers, & Schum, 1977; Hogan & Kitagawa, 1983).

For female adolescents, the risk of pregnancy is related to race (Alan Guttmacher Institute, 1981; Ventura, 1984), low socioeconomic status (Burden & Klerman, 1984), and absence of the father, number of siblings, school difficulties, and family stress (Dryfoos, 1985). Among adolescent men, early fatherhood is associated with school difficulties, low parental economic status (Robbins, Kaplan, & Martin, 1985), and race (Barret & Robinson, 1982).

The roles of the demographic variables, including socioeconomic status, race, and ethnicity are multidimensional. This is clearly illustrated by a research perspective on the complexity of the early childbearing phenomenon (Mott, 1986). Initial studies indicated that the mother's age at the time of her first pregnancy was related to the number of subsequent pregnancies she would experience. It was believed that a higher probability of repeated pregnancies existed when she became pregnant at an early age. More recent research reveals that these data differentiate by age among population subgroups. There are no significant differences in repeat pregnancies between White adolescents who experience early childbirth and White women who postpone their first birth until their early 20s. Black adolescents, who give birth at an early age, are more likely to have a rapid follow-up birth, and the younger the mother is, the sooner this second child will be born. Hispanic women are more likely than either their Black or White counterparts to have a second baby quickly follow an early first birth, but there are not any significant differences between the younger and older Hispanic teenagers regarding the timing of this second birth (Mott). These subtle differences have implications for early and primary prevention programs.

Interpersonal Variables

The quality of the relationship between the parents and the teenager is a relevant antecedent factor that contributes to the early initiation of premarital sexual relationships. The degree of interpersonal closeness versus distance or alienation in the mother-daughter relationship, as well as estrangement from the family, are factors that have been found to be significant antecedents to adolescent pregnancy (Chilman, 1980; Olson & Worobey, 1984). A strong relationship with the mother can prevent the daughter from prematurely losing herself in relationships with others. Abernethy (1974) found that family experiences during adolescence are critical in determining personality traits and predispositions for early pregnancy. If the parents' marriage is characterized by distance and hostility, promiscuity and irresponsible use of contraception are common outcomes. Poor identification with a mother "who was neither warm nor respected" is a common expression of adolescent mothers in this study (Abernethy).

Fox (1980) gathered data on communication about sexual behavior and found that a higher frequency of communication with the mother about sexual questions is associated with the daughter exhibiting a more responsible pattern of sexual behavior. Frequent discussions provide an "anticipatory rehearsal," and permit the daughter to accept her sexuality. This open communication also desensitizes the topics of sex and birth control, and facilitates the probability that a discussion about responsible sexual behaviors will also occur with future sexual partners.

Psychological Variables

Adolescent mothers may be especially vulnerable to emotional problems. Among the traits purportedly manifested in the emotional repertoire of adolescent mothers are (a) weak ego strength (Miller, 1973); (b) self-devaluation (Kaplan et al., 1979); (c) low self-worth (Faigel, 1967); (d) low self-esteem (Thompson, 1986); (e) inability to plan for the future (Rains, 1971); (f) proclivity toward denial (Rader, Bekker, Brown, & Richardt, 1978); (g) risk-taking behavior (Miller); and (h) external locus of control (Connolly, 1975; Thompson).

Although studies have indicated that the life changes that accompany pregnancy and childbearing contribute to the psychological stress of teenage mothers, the two variables that are systematically shown to be associated with their emotional distress are poverty and isolation (Barth et al., 1983). Socioeconomic characteristics have a significant impact on the emotional well-being of adolescent mothers. Evidence strongly suggests that the lack of social supports and a reduced economic status mediate the stress of adolescent motherhood (Barrera, 1981; Furstenburg & Crawford, 1978; Grow, 1979), and McGee (1982) contended that the social and economic limitations that are imposed on single, adolescent mothers are sufficient to generate many of the adverse characteristics associated with teenage mothers. Furthermore, these emotional difficulties continue to plague low-income mothers even after their children have entered high school (Brown, Adams, & Kellam, 1981). The debilitating influence of welfare status is seen as a major contributor to young mothers' distress (Burden & Klerman, 1984; Ensminger, 1979).

Barth et al. (1983) maintained that social supports in the form of social, economic, and educational assistance is the primary need for teenage mothers. Their study revealed that social and economic factors contribute more to the adolescent mother's emotional well-being than does pregnancy or parenthood. Although the aspect of motherhood may somewhat distress the adolescent, the lack of emotional and social support is the major contributor to her emotional stress, and it is crucial that assistance programs for adequate social and material assistance be initiated (Barth et al.).

Correlates of Early Childbearing to Education, Career, and Economic Well-Being

A few studies have identified a number of critical concerns for teenage mothers and their offspring (Center for Population Options, 1985; Children's Defense Fund, 1988; Edelman, 1987; Furstenburg, 1976; Hofferth & Moore, 1979; Kellam, 1979; McCarthy & Menken, 1979; Morrison, 1978; National Research Council, 1987; Russ-Eft, Sprenger, & Beever, 1979; Sandler, 1979; Ventura, 1984; Wilson, 1986). The concomitant events of adolescent pregnancy and the long-range educational and economic consequences have serious implications for this growing population of at-risk youth and their children.

There are significant relationships among an early first birth, education, meager marketable skills, and a limited, financially unrewarding labor force experience. School failure is a recurring predictor in both the antecedent and accompanying factors related to adolescent pregnancy. The "status failure" explanation, proposed by Robbins et al. (1985), suggests that marginal students become pregnant because parenthood seems a viable alternative to the self-devaluing experiences in the educational system. School stress, therefore, is considered to be a strong predictor of adolescent pregnancy. Conversely, the degree of educational attainment is highly correlated with the age of the mother when she bears her first child (Rindfuss, Bumpass, & St. John, 1989). Moore and Hofferth (1978) found that, in virtually every study, the age of the mother at the time of the birth of her first child presents the strongest influence on her educational attainment. The primary effect of a birth on educational achievement occurs among women who bear their first child during their high school years.

Adolescent mothers, because of their loss of education, generally not only work less, but have lower hourly wages, earn less money annually, and obtain jobs with lower occupational prestige and less opportunity for advancement. Eight out of 10 women who have their first child at age 17 or earlier never complete high school (Moore & Hofferth, 1978). Even when the first birth occurs at age 18 or 19, the rate for dropping out of school is 1.4 times greater than that of the general teenage population (Alan Guttmacher Institute, 1976). Other investigators (Scales & Gordon, 1979; Trussell, 1975) found that the younger the girl is at the time she becomes pregnant, the less likely she is to return to school after delivering her baby. Teenage mothers have an 85% dropout rate, whereas childless girls have a 7% to 9% dropout rate (Alan Guttmacher Institute, 1976). Young women who have a first birth before age 15 have an average educational attainment of only 8.9 years. This is 4 years less than the national average. Women who bear their first child at ages 16 or 17 receive approximately 10.5 years of schooling, 18-year-old mothers attain 11.3 years, and 19- to 20-year-old mothers average 11.9 years. Even women who become mothers at ages 21 to 23 are below the national average. They typically obtain 12.7 years of education, whereas women who have their first child at age 24 or older have an average educational level of 13.5 years. These additional years of education can create significant elevations in the possibilities for increased wages and job opportunities (Dillard & Pol, 1982).

Pregnancy not only disrupts schooling but also minimizes the acquisition of vocational skills. The new responsibilities that accompany child care can make it difficult to obtain employment. Welfare often becomes the only viable alternative. In a New York City study (Pressor, 1980), it was found that 72% of mothers who gave birth between the ages of 15 and 17 were being supported by Aid to Families of Dependent Children (AFDC). This study also reported that one third of the mothers who have their first child between the ages of 13 and 15 live below the federal poverty level. This incidence is 2.6 times greater than that of women who postpone childbearing until the age of 20 or later (Pressor).

Parenthetically, as the training and educational demands of our society become more sophisticated and the opportunities to meet these demands continually become exhausted, without prerequisite skills, the adolescent mother becomes disenfranchised and invariably handicapped. As Table 1 shows, the probability of opportunity, education, employment, and economic stability is diminished, and single parenthood becomes synonymous with poverty. Furthermore, the public cost of adolescent pregnancy is expensive. For each family that originated from a teenage pregnancy, the cost is approximately $14,000 per year for a 20-year interval. In 1986 alone, $18 billion in federal assistance (including AFDC, food stamps, and Medicaid) went to families that emanated from a teenage birth (Children's Defense Fund, 1988).

Summary

In summary, the variables associated with teenage pregnancy are complex and numerous. Lists of the antecedent and attendant demo-

TABLE 1

Profile of Adolescent Mothers in the Years After Their Children are Born

	Age of Mother				
	Younger than 15	*15 to 17*	*18 to 19*	*15 to 19*	*20 to 24*
Health					
Receiving late or no prenatal care	65.3%	52.7%	44.8%	30.0%	
Babies born at low birthweight	12.9%			9.3%	6.9%
Marital Status					
Married at birth of child	8.0%	33.2%	49.3%		73.7%
Of mothers who were unmarried at birth of child, percent who married within:					
One year		19.1%	24.0%		19.4%
Three years		38.6%	44.1%		41.5%
Of women who marry at various ages, percent who separate within five years:		23.7%	14.8%		9.9%
Repeat Pregnancies and Births					
Of women who have their first child at various ages, percent who have a repeat birth within:					
Two years	26.0%	20.0%	22.0%		
Three years	42.0%	41.0%	46.0%		
Of teens having a premarital first pregnancy, percent who have a second premarital pregnancy within:					
12 months				17.1%	
18 months				25.5%	
24 months				37.8%	

School Completion					
Of high school sophomores, percent who dropped out before graduation:					
Unmarried, with child		51.4%			
Married, with child		75.4%			
Unmarried, no child		7.9%			
Married, no child		59.6%			
Percent of teens who had their first child at various ages, who had completed high school by ages 20 to 26:					
Total		50.2%	70.2%	61.1%	90.0%
Diploma		32.0%	60.7%	47.6%	86.0%
G.E.D.		18.2%	9.5%	13.0%	4.0%
Poverty					
Of women in their mid-20s who had their first child at various ages, percent whose incomes were below 150% of poverty:	78.0%	50.0%	51.0%		29.1%
Welfare Recipiency					
Of women who had their first child at various ages, percent who started receiving welfare within four years:					
Total (married and unmarried)		52.0%	42.0%	46.0%	
Unmarried at birth of child		73.0%	73.0%	73.0%	
Of women who had their first child at various ages and who started receiving welfare, percent who left welfare within four years:					
Total (married and unmarried)		70.0%	82.0%	76.0%	
Unmarried at birth of child		66.0%	76.0%	71.0%	

From *Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency* (p. 9), 1988, Washington, DC: Children's Defense Fund. © 1988 by The Children's Defense Fund. Reprinted by permission.

graphic, interpersonal, and psychological variables, influences, and personal characteristics are provided below (Alan Guttmacher Institute, 1981, 1984; Children's Defense Fund, 1988; Crim, 1987; Cvetkovich & Grote, 1975; Finkel & Finkel, 1975; Goldsmith, Gabrielson, & Gabrielson, 1972; Hornick, Doran, & Crawford, 1979; Jorgenson, King, & Torrey, 1980; Koenig & Zelnik, 1982; Planned Parenthood Poll, 1986; Pressor, 1980; Shah, Zelnik, & Kantner, 1975; Zelnik & Kantner, 1979).

Demographic Variables

1. Younger than 18 years of age, with a growing population of adolescents younger than 15 years of age;
2. Low socioeconomic status;
3. Minority group membership;
4. Academically behind in school; low grade point average;
5. Larger than average family;
6. Familial correlates; and
7. Absent father figure.

Interpersonal Variables

1. Not committed to a steady relationship;
2. Sporadic, unplanned sexual activity;
3. Nonusage of contraceptives;
4. No access to free, confidential family planning services;
5. Distant or hostile family relationships;
6. Often in high-stress situations;
7. Sexually permissive friends;
8. Tolerant family attitudes toward early sexual activity and pregnancy;
9. Fewer demands, greater rejection, and more casualness in mother-daughter relationship; and
10. Less love, less attention, and less self-disclosure in relationship with mother.

Psychological Variables

1. Desiring pregnancy to fill a love void, or to secure a commitment from a partner;
2. External locus of control;

3. Low self-esteem;
4. Attitudes of fatalism, powerlessness, and alienation;
5. High levels of anxiety;
6. Low ego strength;
7. Risk-taking behavior; pleasure-oriented attitudes; and
8. Depression.

Composite Profile of the Average Unwed Adolescent Mother

1. Her mother or sister was a teenage mother.
2. She was reared in a single-parent home.
3. Her family was often a recipient of AFDC.
4. She does poorly in school.
5. She is influenced by peer pressure.
6. She has a rigid sense of the gender roles.
7. She is experiencing family stress.
8. She feels she has no control over her life.
9. She has low self-esteem.

Approaches to Counseling

From a counseling perspective, there are a number of salient issues to consider. The problem of adolescent pregnancy can be prevented at various developmental stages of behavior and experience. The adolescent who is not engaging in sexual activity can be encouraged to continue abstinence until he or she is mature enough to assume responsibility for his or her sexual conduct. The adolescent who is already sexually active can be provided pertinent contraceptive information and counseling. The adolescent who is pregnant needs appropriate medical care and a versatile method of intervention that can effectively address all the problematic aspects of teenage pregnancy and motherhood.

The trend in current counseling processes and psychotherapy is toward a multidimensional, multidisciplinary, and multifaceted approach that does not rigidly attempt to fit clients into a preconceived treatment plan (Lazarus, 1984). One such approach, Multimodal Therapy (Lazarus, 1981), is a systematic and eclectic orientation that allows the counselor to take into account the uniqueness of each individual and to tailor a program that addresses the special issues and problems of that person. The emphasis in this therapeutic approach consistently pertains to what is the best outcome for the individual, couple, or group.

The following case study and intervention strategies are provided to illustrate the multimodal approach as one counseling alternative for the adolescent population.

Individual Counseling Approach

Jane was a 17-year-old high school senior. She was intelligent (IQ 119), and had previously demonstrated conscientious behavior and above-average academic achievement in school. She had few close friends, was not involved in many school-related extracurricular activities, and was considered to be shy and introverted by her teachers.

Jane was referred to the counseling office because she was exhibiting a behavioral transformation that included frequent absenteeism and declining grades. During the initial interview Jane appeared despondent, withdrawn, and was reluctant to discuss her current attendance and academic progress. She was encouragingly assured that the counselor would be available at any time for future conferences.

Jane returned to the counseling office the next afternoon. She had experienced some negative encounters with the teaching staff, and she was agitated and crying. She expressed frustration, anger, and fear regarding her academic progress, and during the counseling session, she revealed the underlying problem that was masked by her poor attendance and declining grades. Jane was 4 months pregnant.

Jane had moved out of her family home to live with her 19-year-old married boyfriend, John. This was her first intimate relationship. John was currently separated from his wife and had two children. The youngest child was 2 weeks old. John was a high school dropout and had been immature and irresponsible with his interpersonal relationships in the past. He suggested that Jane either have an abortion or relinquish the child for adoption. He viewed the baby as a threat and a potential financial burden, and told Jane that their relationship would not continue if she decided to keep the baby.

Jane had been struggling alone with her dilemma regarding a possible abortion, and when she was informed that she had passed the 12-week time limit to terminate the pregnancy, she expressed guilt as well as intense relief.

Jane's mother apparently believed that when her children became teenagers, she was no longer responsible for their care. According to Jane, her mother had condoned Jane's living arrangement with John, but she was unaware that Jane was pregnant. It seemed that Jane's primary support system (parents) was absent, and this fact created an additional predicament for the counselor and the counselee.

Numerous important considerations and issues emerged from this case. The apparent concerns were: (a) medical treatment of a minor, and (b) Jane's parents' neglect of and lack of responsibility toward their daughter. The counseling issues that arose were: (a) whether Jane would keep the baby or plan to have her child adopted; (b) the prospects of a marriage to John; (c) Jane's educational and career goals; (d) her own health and the future well-being of her child; and (e) her need to communicate with her mother about her pregnancy. Finally, at the emotional level, it was important to understand that Jane seemed to be receiving "double-bind" messages from John. If she put the baby up for adoption, she could stay with John and, presumably, their relationship would remain intact, but she would lose the child. If she kept the baby, she would lose John (and her first intimate relationship). Hence, the issues of separation and loss were obvious concerns for Jane and the counselor.

Jane eventually decided to set three goals. First and foremost, she would inform her mother about her pregnancy. Second, she would develop and implement a plan of action for herself regarding her physical well-being, and third, she would clarify her relationship with John.

Multimodal Therapy. A recommended counseling model to use with an individual, or with groups of adolescent mothers, is a multimodal approach, an application of Multimodal Therapy (Lazarus, 1981). This method of therapy is based on the assumption that counselees (or clients) are usually troubled by a multitude of specific problems, and an eclectic counseling program should be formulated to deal with each particular problem. Multimodal Therapy uses a unique assessment procedure that extensively examines both the client's individual sensory, imagery, cognitive, and interpersonal factors, and the interactive effects of these components. Lazarus (1984) provided a framework of seven modalities that are used to conduct this assessment, and this scheme is represented by the acronym, BASIC ID (B = Behavior; A = Affect; S = Sensation; I = Imagery; C = Cognition; I = Interpersonal Relationships; D = Drugs/Biology). Keat (1979) later modified the BASIC ID to address the needs and concerns of various populations, including children.

"The BASIC ID is presumed to comprise human temperament and personality" (Lazarus, 1984, p. 492), and it is assumed that all the emotions attributable to an individual can be accounted for by examining the components and interactions within that person's BASIC ID. It is also considered essential for the assessment to recognize and include the factors that are not addressed by the BASIC ID, such as sociocultural, political, and other macroenvironmental events (Lazarus, 1984). The great depth and detail entailed in the multimodal's examination of the sensory, cognitive, and interpersonal constituents and their interactive effects enable the counselor to transcend the confines of most cognitive-behavioral approaches.

This conceptual model empowers the counselor to evaluate the counselee systematically and comprehensively. By determining the areas of strengths and weaknesses, the counselor and counselee can develop a treatment plan that has a multidimensional influence on behavior.

Basic ID

- B **Behavior** (observable habits, behaviors, and activities);
- A **Affect** (feelings and emotional reactions);
- S **Sensation** (physical concerns, sensory responses);
- I **Imagery** (images and fantasies);
- C **Cognition** (rational and irrational beliefs, goals, plans, philosophies);
- I **Interpersonal Relations** (relationships with others); and
- D **Drugs/Diet** (broadly defined as biological functioning, diet, health, and wellness).

The value of Multimodal Therapy is that it attends to specific problems or difficulties within a give modality as well as the interactions between this modality and each of the six other dimensions. When dealing with the multidimensional aspects of behavior, affect, sensation, imagery, cognition, and interpersonal relations (as well as focusing on the details about nutrition, exercise, and health concerns in the D modality), the emphasis is fundamentally educational. This blueprint of strategies enables the counselor to modify faulty coping techniques, offer guidance, provide a nurturing relationship, give congruent information, correct misconceptions, and deliver the support and encouragement necessary to assist the counselee in reaching her goals.

Counselees who present a wide range of concerns in a number of developmental areas (poor social skills, depression, anxiety, low self-esteem) can be particularly responsive to the multimodal model. When the needs of the counselee's entire behavioral repertoire are systematically addressed, the interventions can relieve the feelings of panic, frustration, and hopelessness that are often manifested in counselees with multiple problems. This method can be especially effective with adolescent mothers, who seem to exhibit a number of underlying social, emotional, and behavioral problems. This structure also allows the counselor to maximize the use of referral sources and adjunct modes of treatment. The multimodal orientation minimizes the use of time while it increases the personal and emotional benefits to the adolescent counselee (Lazarus, 1984).

Case Study Application

Jane manifested a broad range of concerns, so a multimodal assessment using the BASIC ID was employed during her counseling process. Table 2 details her individual assessment and treatment plan.

One of the basic assumptions of the multimodal approach is that the amount of effort expended by the counselor and the counselee will determine the stability and durability of the results of the counseling process (Lazarus, 1984). As the amount of adaptive and coping skills learned in therapy increases, the probability of a relapse to former dysfunctional behavior decreases. These enduring changes seem to depend on the combination of techniques, strategies, and modalities advocated by this therapeutic procedure.

During the counseling sessions Jane learned new and appropriate cognitive and behavioral skills, and the therapeutic process enabled her to make modifications in her maladaptive beliefs and self-defeating behaviors. The counseling process adhered to the basic premise of Multimodal Therapy that clients are usually troubled by a multitude of specific problems that should be dealt with by a similar assemblage of appropriate interventions (Lazarus, 1984). The counseling process focused on (a) positive reinforcement, (b) owning and accepting feelings, (c) changes in self-image, (d) cognitive restructuring, (e) nonjudgmental acceptance, and (f) recognizing and understanding paradoxical maneuvers or double-bind communications. Education, information, and training facilitated Jane's changes in assertive behavior, responses to stress, and the development of new problem-solving and interpersonal skills. For example, Jane's counselor successfully employed the principles of stress inoculation therapy (Meichenbaum & Cameron, 1973), a type of self-instructional training focused on altering dysfunctional self-statements in order to restructure a person's characteristic approach to stressful situations. This technique, which has been used to help people cope with anxiety (Meichenbaum & Novaco, 1978) and anger (Novaco, 1979), was particularly applicable in Jane's case. She was experiencing anxiety with her academic performance and her affiliation with her teachers. She was also angry and frustrated with her relationship with her partner. A critical concern for Jane was that she learn to obtain some control over her inner conflicts, and eventually gain self-sufficiency in her coping skills.

TABLE 2

Case Study: Jane

Individual Multimodal Counseling Profile for Adolescent Mothers

Modality	*Problem Assessment*	*Related Intervention*
Behavior	Avoiding telling mother of pregnancy	Behavior-rehearsal via taped playback
	Avoiding prenatal care	Participate in prepared childbirth program
	Negative self-statements	Positive self-talk assignments; goal rehearsal
Affect	Depression	Increase range of positive reinforcement
	Internalized anger	Assertiveness training; behavioral rehearsal
	Feelings of guilt and anxiety	Self-hypnosis with positive imagery
	Feelings of loneliness and emptiness	Relationship building; communication skills
Sensation	Ambivalent feelings about prenatal care	Diet, exercise, improved eating habits

	Concern over well-being of baby	Education and training in anatomy and physiology
	Tension and fatigue	Relaxation training; stress inoculation
	Butterflies in stomach	Abdominal breathing exercises
Imagery	Telling boyfriend she will keep the baby	Goal rehearsal; coping imagery
	Image of self as incapable as student and mother	Social skills; assertiveness training; images of mastery; concentration on positive skills; diminish feelings of hopelessness and depression
	Image of self as unemployed and on welfare	Assertiveness training
Cognition	Lack of prenatal Information	Bibliography
	Lack of education and occupational data	Career counseling; individual assessment
	Irrational self-talk about low self-worth	Dispute irrational ideas
	Numerous regrets	Dismantle categorical imperatives (remove shoulds, musts, and oughts)

TABLE 2 *Continued*

Modality	*Problem Assessment*	*Related Intervention*
Interpersonal Relations	Fear of rejection by boyfriend and significant others	Behavioral rehearsal, assertiveness and communication training; time projection techniques
	Inconsistent relationship with parents	Family conference roleplaying, attend prepared childbirth class with mother
Drugs/Diet	Poor dietary habits	Encourage good nutrition

The strategies of Multimodal Therapy were therapeutic for Jane. She was provided an organized framework in which she could systematically address and resolve the specific deficits and excesses in her behavioral patterns.

The multimodal approach to counseling can also be extremely effective when it is applied to counseling groups of adolescent unwed mothers. Support groups are frequently advocated as the preferred mode of teaching and treating this adolescent population because the group process can provide a richer and more realistic training milieu for the resolution of interpersonal conflicts and deficiencies than can individual counseling.

Approach to Group Counseling

Group counseling is particularly suitable for adolescents because it provides a place in which they can discover that their problem situations are not unique. The group experience can provide opportunities for communication, observational learning, modeling, role playing, and behavior rehearsal, and can supply a safe environment where adolescents can express and encounter conflicting feelings. Adolescent group therapy is generally directed toward the elimination of the dysfunctional behaviors that circumvent self-sufficiency, and provides an active atmosphere in which adolescents can learn alternative appropriate methods of dealing with situations. Finally, as the group offers unconditional acceptance and supports the members when they attempt new behaviors, group participants will gain self-esteem, and they will eventually assume more control over their own behavior.

The multimodal approach to group therapy is focused on eliminating specific excesses and deficits in each group member's multimodal profile, as well as increasing the self-sufficiency of the entire group. The initial focus of the group is devoted to the construction of Modality Profiles for each group member (See Table 3). An attitude and atmosphere emphasizing the cooperative pooling of resources and the deliberate creation of helpful togetherness is stressed, and the fundamental goal of the group is to learn an adaptive set of coping skills that can be generalized to other situations.

Multimodal applications can also provide a valuable dimension to teen-parent support groups. A teen-parent group, which is designed to concentrate on self-sufficiency skills and to cooperate extensively with community agencies, can address the unique needs and concerns of young parents. One such group, Mothers and Others Means Success (M.O.M.S. (Thompson, 1986), focuses on ameliorating particular problems in an informal, safe, relaxing, accepting, and respectful atmos-

TABLE 3

Multimodal Group Counseling Profile for Adolescent Mothers

Modality	*Problem Assessment*	*Related Intervention*
Behavior	Poor academic performance and attendance problems	Self-contracting; recording and self-monitoring
	Negative self-statements	Practice positive self-talk
	High risk-taking behavior (drugs, child neglect)	Provide accurate information about potential risks to self and to child
	Diciplining children by yelling or hitting	Teach operant training principles in child management
Affect	Feelings of low self-worth	Increase range of positive reinforcement; focus on self-value and self-talk
	Anger toward significant others	Exercises in anger expression
	Conflict with others	Behavioral rehearsal; role reversal
	Depression	Grief counseling (e.g., loss of father of child, significant others and their approval, loss of status with peer group); discuss difference between thoughts and feelings; identify positive and negative categories

Sensation	Anxiety and depression over present circumstances and future goals	Anxiety-management training; goal rehearsal or coping imagery
Imagery	Unproductive fantasies	Guided imagery; reduce the discrepancy between one's real and ideal self-image; positive imagery; imaging rehearsal; idealized self-image; time projection technique
	Image of self as incapable	Role rehearsal
Cognition	Poor study habits	Study skills training; assertiveness training; share feelings about school, favorite subjects; discuss performance levels; seek specific subject or source of underachievement; examine behavioral consequences of underachievement; develop contractual agreements with core teachers
	Lack of educational or occupational information	Career counseling; assessment and information
	Sexual misinformation	Factual information; bibliography
	Expectations of failure	Positive self-talk

TABLE 3 *Continued*

Modality	*Problem Assessment*	*Related Intervention*
Interpersonal Relations	Poor relationships with peers	Social skills and assertiveness training; share feelings about family and friends; discuss relationships with peers
	Conflicting or dissatisfying interpersonal relationships	Assertiveness training; communication skills training; conflict resolution strategies; role play and practice with communication skills
Drugs/Diet	Poor dietary habit	Involvement in weight reduction program; nutrition and dietary information for self and for offspring

phere. Table 4 outlines the group objectives and intervention strategies of this program.

Approaches to More Extensive Programs

Individual and group counseling approaches can be effective in addressing the emotional deficiencies of small populations of pregnant and parenting teens, but there still exists an urgent need for expanded school programs directed toward the prevention of teenage pregnancy, and for renewed efforts to formulate and initiate plans that will increase the socioeconomic resources of adolescent mothers.

Recent studies by the Children's Defense Fund (1988), Edelman (1988) and La Rue and Miller (1988) identified a number of crucial issues in increasing the motivation and capacity of teens to prevent premature pregnancy and in promoting their development of competent parenting abilities and appropriate interpersonal skills. The following inventory of needs is provided as a suggested direction for the advancement of relevant programs.

1. *Education and strong basic skills.* Youths who are behind a grade or have poor school attendance are at high risk for early parenthood. Low-income and minority teens have greater rates of school failure.
2. *Jobs, building work-related skills, and work exposure.* Teens who perform poorly in school and become teen parents are often students with poor work-related skills. Because of the lack of exposure to workplace norms, many adolescents manifest behavioral patterns that are maladaptive to the workplace.
3. *A range of nonacademic opportunities for success.* Children and teens need to feel good about themselves. They need a clear vision of a successful and self-sufficient future. Self-sufficiency is related to self-esteem and self-perception. For youths who are not doing well in school, nonacademic avenues for success are crucial.
4. *Family life education and life planning.* All teens need sexuality and parenting training education to facilitate the integration of factual information into their concepts about themselves and their future. Parents, schools, and religious institutions need to communicate more effectively with the young about sexuality.
5. *Comprehensive adolescent health services.* Convenient health services that provide comprehensive care are needed for the teenage population.

TABLE 4

Group Objectives for Nine-Week Structured Sessions of M.O.M.S

The general goals for M.O.M.S. (Mothers & Others Means Success, (Thompson, 1986) are to reduce the incidence of future pregnancy and to increase the educational and employment opportunities of this high-risk population.

Sessions focus on adolescent sexuality, self-esteem, problem-solving skills, and other concerns of group members. The developmental and problem-solving orientation of this group is intended to foster an informal support group for the participants.

The major goal of this group, as a family educational model, is to help individuals cope with themes and conditions they currently perceive as insurmountable (such as child care or parental conflicts). Efforts will be made to begin interventions at the present functioning level of the group, and to employ viable methods to address their concerns.

Group Objectives

1. Address specific areas of concern individual group members hold
   A. Facilitate discussion of parenting skills.
   B. Identify the expectations and roles of parenthood.
   C. Provide a local resource person from a community day-care unit for presentations to the group on entertaining small children and making inexpensive, educational toys.
   D. Utilize the local library, public health department, mental health center, local child-care association, and the local department of social services to facilitate discussions on topics of special concern.
   E. Teach the stages of child development from birth to 5 years of age.

2. Develop individual multimodal profiles
   A. Identify individual strengths and weaknesses.
   B. Develop a systematic treatment plan.
   C. Share individual goals with the group.

3. Employ the services of resource agencies within the city to strengthen recipients' self-sufficiency skills as parents and as prospective parents
   A. A resource person from a local federal project will present vital information to group members about child development and discipline.
   B. A modified parenting program that focuses on such issues as responsibility, consistency, and encouragement will be presented as a series of structured experiences by a resource person from the local court division unit.
   C. A workshop on necessary job entry skills, interviewing, and job application procedures will be provided.
   D. The services of the local social service or community services board will be utilized.

TABLE 4 *Continued*

4. Improve self-esteem
    - A. During the group process, the leader will focus on the members' strengths rather than on their weaknesses.
    - B. Positive reinforcement from other members will be encouraged.
    - C. Cooperative interaction among group members and structured strategies will facilitate the development of self-esteem.
5. Improve problem-solving skills
    - A. Leader will guide the group through problem-solving processes by stimulating, motivating, and involving the members in discussions on topics selected by the group.
    - B. Members will repeatedly rehearse and role play authentic situations. Focus will center on: (a) gaining control of life situations; (b) enhancing the individual's sense that she has the power to influence her environment; (c) understanding that choices and decisions have consequences that can affect one's life.
    - C. Members will identify the stress response and learn techniques to cope with stress and to manage stressful situations and problems.
6. Offer family planning and sexual information to adolescents
    - A. A local family planning workshop will be presented.
    - B. A basic understanding of the reproductive process, alternative methods of birth control, and the identification of sexually transmitted diseases will be provided.
7. Develop a continuing informal network among the group participants

6. *A national and community climate that makes teenage pregnancy a leading priority*. It is necessary to have caring adults who will provide positive role models, values, and support for teens.
7. *Development of broad-based educational programs*. It is essential that programs that place sex education within the larger context of life-skills development be implemented.
8. *Federal intervention*. The federal government should withhold funds from schools that exclude pregnant adolescents, and provide incentives that will facilitate the involvement of parents and grandparents in caring for the pregnant teenagers in their families.
9. *Increased community health services*. It is necessary to establish programs that address issues such as poor family communications, single parenting, conflicts between parents and ado-

lescent children, and early identification of abuse and abusive patterns.

10. *Policies and programs that focus on the family as well as on the individual.* The principal focus should be prevention, with efforts targeted in five areas: (a) reducing the incidence of teenage pregnancy; (b) reducing the incidence of repeat teenage pregnancy; (c) reducing the number of teenage school dropouts as a result of pregnancy and parenting; (d) reducing the number of babies born to low-income mothers who have not had comprehensive health care; and (e) providing good basic skills to young people to increase their chances to graduate from high school, obtain a college education or get a job, and generate healthy families (Children's Defense Fund, 1988).

Conclusions

The information provided in this chapter establishes the necessity for parents and private and public agencies to generate a concerted and extended effort toward increasing the self-sufficiency and personal success of adolescent unwed mothers. The interventions provided for this population should not only apply to the needs and concerns of the mother, but must simultaneously address the welfare of the unborn child. Adolescent mother programs must also teach adequate parenting skills and provide the structures that enable the counselor to use an approach that will facilitate the future well-being of the mother and her child.

The research on self-concept and maladjustive behaviors has indicated that a large number of adolescent unwed mothers could be highly susceptible to distress and emotional disturbance. Essentially, they deviate from the norms of their peer group because of the roles and responsibilities they must assume as a single parent. It is imperative that individual or group counseling be provided to assist this growing population of extremely vulnerable young people.

Because this adolescent population typically manifests an extensive range of disturbances, the most comprehensive and efficient method of intervention for teenage mothers could be a multimodal behavioral group counseling approach. The following recommendations are provided for possible consideration in the counseling process.

1. Interventions should focus on conflict, instability, low self-esteem, and self-sufficiency.
2. Education and training should be provided to increase personal management and problem-solving capabilities, and to generate sound job-entry skills.

3. The counseling process should facilitate the enhancement of social competence, and the ability to develop healthy interpersonal relationships.
4. Above all, the counseling process should be directed toward the adolescent mother's realization that she is ultimately responsible for herself, and that the achievement of her aspirations will predominantly depend on the amount of effort she extends toward her chosen goals. (For additional information on available resources, see the appendix.)

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Appendix

Collective Resources

Information, Programs, and Funding Available for Adolescent Health Services and Pregnancy Prevention and Care Services

Child Trends, Inc.
Fact Sheet: Facts at a Glance
2100 M Street, NW
Washington, DC 20037
(202) 223-6288

Healthy Mothers/Healthy Babies Coalition
600 Maryland Avenue, SW
Washington, DC 20024
(202) 628-5577

Adolescent Pregnancy Programs
Public Health Service
Department of Health and Human Services
330 Independence Avenue, SW
North Building, Room 1351
Washington, DC 20201
(202) 245-1042

Information on Statistics and Research on Sex Education and Teenage Pregnancy

American College of Obstetricians and Gynecologists
Newsletter: *NAACOG Newsletter*
600 Maryland Avenue, SW
Washington, DC 20024–2589
(202) 638-5577 or (800) 533-8822

Center for Population Options
1012 14th Street, NW, Suite 1200
Washington, DC 20005
(202) 347-5700

The Alan Guttmacher Institute
111 Fifth Avenue
New York, NY 10003
(212) 254-5656

National Center for Health Statistics
U.S. DHHS/Public Health Services
3700 East-West Highway, Room 157
Hyattsville, MD 20782
(301) 436-8500

Information on Adolescent Pregnancy Initiatives

American Public Welfare Association
1125 15th Street, NW
Washington, DC 20005
(202) 293-7550

Grants That Support Community Education on Teenage Pregnancy and Family Programs

Charles Stewart Mott Foundation
1200 Mott Foundation Boulevard
Flint, MI 48502–1851
(313) 238-5651

Information About the Annual Florence Crittenton Roundtable on Teenage Pregnancy

Child Welfare League of America
440 First Street, NW, Suite 310
Washington, DC 20001–2085
(202) 638-2952

Information About Lobbying, Programs, and Policies That Affect Large Numbers of Children

Children's Defense Fund
122 C Street, NW
Washington, DC 20001
(202) 628-8787

Information on Courses and Programs on Adolescent Sexuality Education

The Health and Education Council, Inc.
7201 Rossville Boulevard
Baltimore, MD 21237
(301) 686-3601

Information on the Saint Paul Story: A Teaching Manual on the Pioneer School-Based Clinics

Health Start., Inc.
640 Jackson Street
St. Paul, MN 55101
(612) 221-3422

Assistance in the Development of Health Care Services for Children in Need

March of Dimes Defects Foundation
Newsletter: *Maternal Newborn Advocate*
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

Healthy Children
641 Huntington Avenue
Boston, MA 02115
(617) 732-1407

Technical Assistance on Forming an Advocacy Network and Policy Development for Family Life Programs in Schools

The National Association of State Boards of Education
701 N. Fairfax, Suite 340
Alexandria, VA 22314
(703) 684-4000

The New Jersey Network for Family Life Education
The Center for Community Education
R. 4087—Kilmer Campus
Rutgers The State University
New Brunswick, NJ 08903
(201) 923-7929 or 923-7798

Information on Training Institutes for Family Life Educators and Curriculum Materials

Family Life Information Exchange (FLIE)
P.O. Box 10716
Rockville, MD 20850
(301) 770-3662

The National Family Life Education Network
P.O. Box 8506
1700 Mission Street, Suite 320
Santa Cruz, CA 95060
(408) 429-9822

Health Education Grants, Programs, and Collaboration

National Family Planning and Reproductive Health Association, Inc.
Newsletter: *NFPRHA News*
122 C Street, NW, Suite 380
Washington, DC 20001–2109
(202) 628-3535

The National Foundation/March of Dimes
P.O. Box 200
White Plains, NY 10602

Publications on Health Policy and Children's Issues

National Governor's Association
Hall of the States
444 North Capitol Street
Washington, DC 20001
(202) 624-5300

National Organization on Adolescent Pregnancy and Parenting, Inc.
Newsletter: *NOAPP Network*
P.O. 2365
Reston, VA 22090
(703) 435-3948

Assistance in Locating Health Information Through Identification of Health Information Resources, Referral Systems, and Free Health-Related Literature

National Health Information Clearinghouse
P.O. Box 1133
Washington, DC 20013
(800) 336-4797

Funding of Programs to Improve Access to Personal Health Care for the Most Underserved Population Groups, Particularly Adolescents

The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, NJ 08543-2613
(609) 452-8701

Bibliographies of Curricula, Texts, Audiovisual Materials, and Trade Publications for Children, Teens, Adults, Teachers, and Parents, And Subscriptions to the DIECUS Report

SHARE Resource Center on Teen Pregnancy Prevention
P.O. Box 2309
Rockville, MD 20852
(800) 537-3788

Sex Information and Education Council of the U.S., Inc.
80 Fifth Avenue
New York, NY 10011
(212) 673-3850

National Maternal and Child Health Clearinghouse
38th and R Streets, NW
Washington, DC 20057
(202) 625-8410

National Resource Center for Youth Service
University of Oklahoma
440 South Houston, Suite 751
Tulsa, OK 74127
(918) 581-2986

Data Archives on Adolescent Pregnancy and Pregnancy Prevention

Sociometrics Corporation
685 High Street
Number 2 E
Palo Alto, CA 94301
(415) 321-7846

Information on Postponing Premarital/Premature Sexual Intercourse

The Human Health Center
Saint John's University
Collegeville, MN 56321
(612) 363-3313

Why Wait
Box 1000
Dallas, TX 75221

Chapter 10

NO GUARANTEE OF IMMUNITY: AIDS AND ADOLESCENTS

Lizbeth A. Gray and Reese M. House

Joshua is a 17-year-old teenager from a typical American family. He has been diagnosed with AIDS. He contracted the virus through sexual experimentation. He has been prevented from attending school. His friends reject him. His brothers and sisters are afraid to be with him. His mother and father cry and feel helpless in the battle to keep him alive. He now weighs 86 pounds. He is often too sick to go out of the house. He will die soon. He is very frightened.

It is relatively easy to talk about high-risk groups, projected numbers, causal agents, transmission processes, and prevention strategies in an intellectual and objective manner. It is harder to speak of the fear of Joshua's death and dying process. It is difficult to embrace the pain that his family experiences as they lose someone they love. This chapter focuses on AIDS information we need to know as counselors working with adolescents. It may seem distant and removed. What we are asking readers to do is learn the information about AIDS, integrate it, and open their hearts to the anguish that AIDS is causing our society. We must learn to understand this disease with both our minds and our hearts.

Introduction

The adolescent has been identified to be at risk in areas ranging from school dropout to suicide. Since being publicly diagnosed in 1981, acquired immune deficiency syndrome (AIDS) has presented a new risk for the adolescent. This epidemic is having a tremendous social and psychological impact on modern society. AIDS can no longer be ignored.

Ramifications of this crisis are far-reaching, and there is no doubt that the health and welfare of the world's population are in jeopardy.

AIDS has claimed over 42,000 lives in the United States as of October 1988 (Centers for Disease Control [CDC], 1988) and 270,000 are expected to die from the disease by 1991 (CDC, personal communication, August 5, 1988). Of the 75,768 Americans who have been diagnosed with AIDS, 305 have been adolescents (CDC, 1988). However, this figure of less than 1% for adolescents is not cause for reassurance. Almost 25% of diagnosed AIDS cases are people in their 20s (CDC, 1988); because of the long incubation period of the virus it is likely that these individuals contracted the disease while still teenagers (Helquist, 1988). Acquired immune deficiency syndrome is now recognized as a global health problem, with 74 countries reporting the disease (Quinn, Mann, Curran, & Piot, 1986). Due to the lack of a curative therapy, this disease now ranks as the most serious epidemic of the past 50 years (Quinn et al., 1986).

Factual Information About AIDS

The cause of AIDS is believed to be a retrovirus that targets and destroys certain white blood cells essential to the functioning of the body's immune system (Levy, Hoffman, Kramer, Landis, Shimabukaro, & Oshiro, 1984). Once the immune system is severely depressed, other opportunistic infections develop that eventually cause death. After exposure to the virus some people are initially asymptomatic, whereas others develop a milder but debilitating illness called AIDS-related complex (ARC). There is no cure for AIDS. Once an individual contracts the AIDS virus, he or she is infected for life. It has been estimated that 99% of persons infected with the causative agent, human immunodeficiency virus (HIV), develop AIDS and die from AIDS-related illnesses within 5 to 10 years (CDC, personal communication, August 5, 1988).

HIV is not as contagious as other well-known viruses such as the common cold. This virus does not seem to be transmittable through casual social contact such as coughing, sneezing, shaking hands, sharing eating utensils, or using the same telephone (Oregon State Health Division [OSHD], 1986). The virus is actually fragile and is quickly killed on environmental surfaces when treated with disinfectants (OSHD, 1986). Medical authorities have repeatedly stated that transmission occurs only through three modes: sexual contact, exposure to infected blood or blood products (*i.e.*, sharing needles, blood transfusions), and passage of the virus from a woman to her fetus or newborn infant (OSHD, 1987). In addition to the infectious blood and semen, vaginal and cervical secretions are known to contain the virus and may account for female-to-male transmission. It is thought that the vast majority of HIV-infected persons are carriers who are unaware that they have been exposed to the virus but are nevertheless capable of infecting others (OSHD, 1987). Saliva, tears, urine, cerebrospinal fluid, and feces may also contain the virus in infected persons, but have not been directly implicated in transmission of the infection (OSHD, 1987).

Since it was first reported in the United States in 1981, AIDS has occurred predominantly in the homosexual and bisexual male population, accounting for 62% of the persons diagnosed with AIDS. Other groups also at risk are: present or past intravenous (IV) drug users, recipients of infected transfused blood, heterosexual partners of AIDS-diagnosed and HIV-seropositive (the condition in which antibodies to the virus are found in the blood) persons, male or female prostitutes and their sex partners, and infants born to HIV-seropositive mothers (CDC, 1988).

In other areas of the world, however, heterosexual transmission of AIDS accounts for a majority of the cases (Quinn et al., 1986). In the United States the number of AIDS cases involving heterosexuals is increasing 100% every 6 months (Van Ness, 1987). AIDS is a problem among all races. Approximately 26% of AIDS cases in the United States, however, are among Blacks, and 15% are among Hispanics (CDC, 1988). The figures far exceed the corresponding percentages of these minority populations relative to the total population of the United States: Blacks compose 12% of the American population and Hispanics compose 6% (DiClemente, Boyer, & Morales, 1988).

The time between infection and the onset of symptoms ranges from 6 months to 5 years or longer. Most individuals infected with the AIDS virus initially have no symptoms. Others develop early symptoms such as tiredness, fever, loss of appetite and weight, diarrhea, and night sweats and swollen lymph glands, all of which are similar to the symptoms of the common cold and flu. Unlike the common cold, symptoms of AIDS are ongoing and persistent. Also, the virus frequently affects the brain and central nervous system, causing confusion or dementia. About 70% of AIDS patients eventually die from two primary infections: pneumocystis carinii pneumonia, or a type of cancer known as Kaposi's sarcoma (CDC, 1988).

Adolescents Are At Risk

Ennis (1987) predicted that by 1991 AIDS will be the number one killer of youth, exceeding the number of deaths resulting from automobile accidents. The basis for this projection can be attributed to a number of factors. Foremost, adolescents are highly sexually active.

> By age 15, 16 percent of boys and 5 percent of girls in the United States have had heterosexual intercourse at least once. By age 17, these rates almost triple for boys and increase 5 times for girls. By age 19 three quarters of all boys and almost two thirds of all girls have been sexually active. ("AIDS and the Education," 1988, p. 5)

One survey estimated that as many as 700,000 young men may have at least 10 sex partners a year, putting them at considerable risk of sexually transmitted diseases including AIDS (Byrd, 1988).

Second, teenagers who are sexually active do not make a practice of using condoms and spermicides, which help prevent the spread of all sexually transmitted diseases, including AIDS. Adolescents between the ages of 10 and 19 constitute 25% of gonorrhea and syphilis cases ("AIDS and the Education," 1988). Only half of sexually experienced adolescents use any form of contraception at first intercourse, whatever the age of the first sexual experience (Alan Guttmacher Institute, 1981).

Third, it has been reported that female adolescents contract AIDS more frequently than adult women (Helquist, 1988). This may be due to the unique anatomic and physiological structure of teenagers.

> Differences in ovarian function and differences in the cervical milieu in young adolescents may facilitate entry and spread of certain organisms. . . . The adult pH (concentration level of acid) is more protective against the invasion of some organisms associated with venereal diseases. (Hein, 1987, p. 293)

In addition to these physiological factors, evidence shows that most adolescents do not seek health care on a regular basis, thereby increasing the chance that AIDS may go undetected (Ennis, 1987).

Also increasing the adolescent's risk for AIDS is the high percentage of teens who have tried drugs or who use drugs on a regular basis. "Over half of high school seniors have used illicit drugs, though only a small percentage of teenage drug users use intravenous drugs and risk contracting AIDS in this way" ("AIDS and the Education," 1988, p. 5). Illicit substances are known to impair the immune system, contributing to susceptibility for contracting AIDS. Use of alcohol or drugs such as amphetamines (speed), amyl nitrite (poppers), cocaine, and marijuana impair judgment and increase the chances of risky or dangerous sexual behaviors.

Some adolescents experiment sexually with the two groups of people known to be at highest risk, homosexual/bisexual men and intravenous drug users; thus, a bridge or chaining effect is established for transmission of the virus to the larger teenage population (Hein, 1987). As a result, teenagers are most likely to contract AIDS from such chained heterosexual contact, rather than direct homosexual contact or intravenous drug use (Helquist, 1988).

Due to the high frequency of sexual activity, failure to use condoms and spermicides, physiological factors, inadequate health care, drug involvement, and the chain effect resulting from experimentation with homosexual contact, teenagers are particularly vulnerable to contracting AIDS. Consequently, it is urgent that the counseling professional consider the implications of the AIDS epidemic when treating adolescents. The counselor must not only keep in mind the high risk to this population, but also the unique characteristics and developmental processes that are the hallmarks of adolescents. For example, teenagers are beginning to form their own independent identities, values, and life-styles. As a professional, one cannot separate AIDS from other life issues. Thus, working with adolescents in the age of AIDS must be done in a comprehensive fashion and in the context of the adolescent's developmental phase of growth.

Response of Teens

Panic and hysteria are common responses to AIDS among adolescents. When understanding this psychological phenomenon, it is critical to recognize that parental attitudes affect the way children think. Often parental attitudes about AIDS, based in part on lack of knowledge and fear of homosexuality, manifest themselves through their teenagers.

The adolescents' anxiety of contracting a deadly disease through sexual activity is heightened by embarrassment and lack of knowledge about sexual intimacy, which are both common to the normal developmental processes of adolescents. One 1986 study found that nearly 80% of adolescents in San Francisco were anxious about AIDS, but had little knowledge about how to avoid the infection (DiClemente, Zorn, & Temoshok, 1987).

On the other hand, many adolescents exhibit a lack of concern or denial with respect to the AIDS epidemic, believing that they are invulnerable. In a study of 250 high school students aged 16 to 19, 73% responded that they were not worried about getting AIDS (Price, Desmond, & Kukulka, 1985). This belief in personal invulnerability, particularly in relationship to health issues, is an intrinsic developmental feature of adolescents.

Most people judge their risk level by imagining a stereotype of who will be involved in a negative event such as contracting AIDS (Weinstein, 1980, 1984; Bauman & Siegel, 1987). People associate AIDS with homosexuals and distance themselves from the possibility of contracting AIDS because they do not fit the stereotype. Weinstein (1984) labeled this as unrealistic optimism. One author found, after surveying a group of children, that they had a fairly accurate understanding of AIDS and possible modes of transmission. However, there was such a strong association with homosexuality that it obscured any sense of direct threat to themselves (Belfer, 1986).

Of 860 randomly selected adolescents, 70% indicated that they were sexually active. More than half stated that they did not worry at all about contracting AIDS. Only 15% said they had changed their sexual behavior because of concern about AIDS, and of this group, only one in five used effective methods of protection (Strunin & Hingson, 1987). Further evidence supporting this position can be found in a recent study of 450 undergraduates that showed that 81% were sexually active. More than 60% of these sexually active students reported having had sexual intercourse during the previous year without using a condom, even though they were knowledgeable about the risks of contracting AIDS (Gray & Saracino, 1988).

The Roles of the Counselor

The counselor needs to undertake multifaceted roles in the battle against AIDS. No singular approach will be effective. The different roles include, but are not limited to: sex educator, networker and advocate, therapist, specialist for the harder-to-reach youth, and referral agent. It is important for the counselor to be aware and knowledgeable of the coexisting and sometimes conflicting responsibilities inherent in these roles. Most important is the recognition that counselors are obligated, by the mere nature of being a part of the helping profession, to actively participate in the battle against AIDS. Counselors are in a pivotal position to prevent the further spread of AIDS in the adolescent population as agents of change in schools, churches, community agencies, government agencies, treatment centers, and private practice. In order to do so, however, the counselor must be knowledgeable and competent in the following areas:

1. Counselors must be comfortable addressing sexuality from a variety of perspectives in order to perform the role of sexual educator effectively.
2. Counselors must be willing to assume the responsibility of providing information about AIDS by implementing age-appropriate curricula in their setting.
3. Counselors must be aware of the networking and advocacy role they need to take in communities, schools, and with parents.
4. Counselors must know how to counsel the sexually active teen and family, the worried-well teen and family, as well as the youth diagnosed with AIDS and family.
5. Counselors must understand the special needs of harder-to-reach youth, such as the runaway, minority teen, substance abuser, and gay adolescent.
6. Counselors must assume the role of referral agent by knowing available community, state, and national resources.

The Counselor as Educator

In the absence of an effective treatment or vaccine against HIV infection, educational programs in risk reduction must continue to be developed to restrict the spread of AIDS in the adolescent population (Koop, 1986). The incidence of new AIDS cases among gay men has plateaued since intense educational campaigns were undertaken in the gay community. This phenomenon indicates that individuals in this high-risk group are becoming educated and, as a result, are willing to change their sexual practices. The goal of counselors should be education and behavioral change for *all potentially and currently sexually active people.* The ultimate goal is an AIDS incidence rate of zero. The intent is to eradicate AIDS in the same manner that society has eradicated other epidemics. The best weapon we have in this battle is education.

It is critical for counselors to expand their definition of counseling by accepting the responsibility for providing this education about AIDS. Education may be done in the schools, in treatment centers, in governmental agencies, in community programs, or in whatever milieu teenagers are found. As AIDS educators, counselors need to be concerned with their own comfort in working with sexual issues and be involved in the development and implementation of creative AIDS curricula.

Counselor comfort. Effective AIDS interventions require that the educator be comfortable talking about sexual issues. No matter how carefully organized AIDS curricula and outreach strategies are, the embarrassed or fearful sex educator can inadvertently sabotage AIDS prevention efforts. Sexual comfort is the most important qualification of a professional sex educator. Counselors are part of the larger American society that typically receives inaccurate sexual information and powerful negative messages about sexuality. This inaccurate information and the negative messages about sexuality impede the professional from talking comfortably about sex.

Communication about sexual issues is frequently made difficult by the profound emotional impact that sexual vocabulary carries. Confusion also arises because sexual terms lack precision. Consequently, not only is effective communication diminished but also the sex educator may transfer negative emotional feelings to the adolescents with whom he or she works.

It is erroneous to assume that counselors have developed sexual comfort as part of their training. A recent survey of 270 counselor education programs indicated that only 44% offered individual sexual counseling courses. The majority of courses were not required. No counselor education program surveyed indicated that sexual training for counselors was overemphasized (Gray, Cummins, Johnson, & Mason, 1989). Thus, the counselor's readiness to conduct AIDS education with adolescents is hampered by societal influence and lack of specific sexual training.

Becoming sexually comfortable is an ongoing process that is circular in nature. In order to be able to educate about sexual issues, one must develop personal sexual awareness and comfort. The sexually uncomfortable person sets an awkward professional atmosphere that invites inhibition. Conversely, success as a sex educator contributes to a positive self-concept. In order to work with adolescents and AIDS, the counselor must consciously begin the process of increasing his or her own sexual comfort. This journey begins by actively addressing the following factors that are likely to contribute to physical, mental, or emotional constraint in the role of sex educator:

1. Inaccurate sexual knowledge;
2. Lack of an explicit sexual vocabulary;
3. Limited practice in talking about sex;
4. Lack of identification and resolution of personal sexual issues; and
5. Sexual values and biases that interfere with openness to alternative life-styles for others.

AIDS curricula. The counselor should take the lead in implementing AIDS curricula in the school and community. Helping professionals have been reticent regarding the subject of sex for too long. It would be a grave mistake for counselors to continue to ignore sexual issues and AIDS in working with adolescents. An equally serious mistake would be to overreact and fail to handle these issues in a professional and holistic manner.

The United States Surgeon General, Dr. C. Everett Koop, ("AIDS and the Education," 1988) has specifically called for schools to stop avoiding frank discussions about sex and start teaching children about AIDS and its dangers at the lowest grade possible. Adolescents must be told that if they are infected with the virus they will eventually die. They must also be explicitly informed about which sexual behaviors put them at risk and which are safer. The responsibility of the counselor is to effectively deliver information about AIDS and safer sex practices, while at the same time helping individuals legitimize healthy sexual options.

Most state health departments have developed AIDS curricula for youth unique to the values and concerns of each geographical area. It is important that the counselor familiarize himself or herself with the local curricula as well as national educational models. To achieve optimum effectiveness, AIDS risk-reduction programs should include information that is age-specific and geared toward adolescents' own needs, perceptions, fears, and concerns. It is suggested that AIDS education be part of a larger educational framework. For example, in a school setting such information could be included in a communicable disease unit or health education unit that can be taught as a part of a comprehensive K–12 health education curriculum. Curricula may be viewed as six separate, yet interfacing, content areas that include medical information, risky and safer sexual behavior, common myths and misinformation, effective sexual decision-making skills, effective sexual communication skills, and safer sex plans. Tables 1 through 6 present examples of the content that can be included in these topical areas.

The Counselor as Networker and Advocate

In the role of networker and advocate, the counselor must be knowledgeable about the particular political issues the AIDS crisis poses. Typical political problems include lack of funding for research and social services, community values that prevent or thwart education about sexual issues, and religious and moral views that reject alternative life-styles or sexual behaviors.

Some individuals believe that AIDS information should not be taught in schools because it will take time away from conventional aspects of the school curriculum. Others believe that promotion of safer sex behaviors will encourage sexual activity among adolescents. Even others say that sex education belongs only in the home and not in the community or school. It is safe to say that opinions are polarized regarding AIDS education for adolescents. All too evident is that some individuals have

TABLE 1

AIDS Curricula: Medical Information

The most recent medical information about AIDS including cause, acquisition, treatment, and prevention must be a part of the curricula. The questions delineated in items 1–6 are ways to approach the topical areas that should be covered when educating adolescents about AIDS.

1. What is acquired immune deficiency syndrome (AIDS)? AIDS is a disorder of the immune system where the immune system is weakened and is unable to prevent life-threatening infections.
2. How is AIDS transmitted? The AIDS virus is spread by sexual contact, needle sharing, or less commonly through tainted transfused blood or its components. The virus also may be transmitted from infected mother to infant during pregnancy, birth, or shortly after birth through breast feeding.
3. How is AIDS not transmitted? AIDS is not spread by casual contact such as: hugging, kissing, holding hands, touching objects handled by an infected person, toilet seats, dishes, telephones, etc.
4. Who can get AIDS? Anyone who has sex with an infected person or who shares needles is at risk. This risk is increased by having multiple sexual partners.
5. Is there a test for AIDS? A blood test can usually identify the presence of antibodies to the AIDS virus. Testing procedures are improving and becoming more accurate. Controversy exists regarding the reliability of the test, who should be tested, and how the results should be handled. Consult your local AIDS project or state health division for the latest information.
6. Is there treatment for AIDS? There is no cure or treatment for AIDS. Treatments for the associated infections that AIDS invites are experimental; regardless of intervention, everyone diagnosed with AIDS is expected to die.

an intense emotional investment in their value position about AIDS and sex education.

Therefore, it is important as a networker and advocate to take into consideration the basic fundamentals of organizational change. The counselor must become familiar with the power structure of the community and lines of decision making within specific agencies or programs. Effective community involvement can make a difference between success and failure in addressing AIDS issues in each community. For example, it is important that all points of view be represented before and during the development of an intervention program. This can be done in part by seeking participation from members of the community

TABLE 2

AIDS Curricula: Risky and Safer Sexual Behavior

It is important to include the latest available information about risky and safer sexual behavior. Educating adolescents in terms of the dangerous-to-safe continuum identified below using straightforward language is essential.

1. *Dangerous behaviors include:* vaginal and anal intercourse without a condom, oral-anal contact (rimming), putting a hand or fist into vagina or anus (fisting), fingers, tongue, or penis touching the vagina during menstruation, sharing sex toys (e.g., vibrators), piercing the skin, sharing needles.
2. *Risky behaviors include:* oral sex on a man without a condom, oral sex on a woman, masturbation on open/broken skin.
3. *Less risky behaviors include:* vaginal intercourse with a condom*, wet kissing, anal intercourse with a condom, oral sex without a condom (as long as ejaculation doesn't take place in the mouth), urinating on unbroken skin.
4. *Safer behaviors include:* dry kissing if neither person has open cuts or sores, masturbation on healthy skin, oral sex on a man with a condom, touching, masage, fantasy, parallel masturbation, clothed body to body rubbing, voyeurism, exhibitionism.
5. *The safest behavior is abstinence from sexual contact.* Solitary masturbation and other individual sexual practices may be considered as options.

***Use of the condom:** It is only with the proper use of a condom that the transmission of the AIDS virus can be prevented. Condoms can break or slip off during sexual intercourse. There is a correct procedure for applying a condom. It is important to put the condom on the penis prior to any sexual contact. Applying the condom includes squeezing and holding the end of the condom while unrolling it over the entire erect penis. The man must withdraw the penis while still erect to prevent the condom from slipping off and leaking. Condoms must not be reused. Latex condoms are effective barriers against the virus; natural animal skin condoms are not effective. Extra protection is provided by latex condoms that have spermicidal jelly containing nonoxynol-9. If additional lubrication is used it is important to avoid oil-based lubricants such as vaseline, mineral oil, or cold cream. Oil-based lubricants can erode and create holes in the condom. A recommended option is the water-based lubricating jelly, K-Y.

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who represent diverse populations and who may disagree about the need for AIDS education. Utilizing a needs assessment model will help in understanding the specific needs of a given community.

Additionally, networking with other educators who have successfully addressed these issues in the community will provide a basis for

TABLE 3

AIDS Curricula: Common Myths and Misinformation

It is critical for the educator to dispel these common myths and misinformation about AIDS and any other myths that are common to adolescents.

1. Only homosexuals get AIDS.
2. Only the sexually promiscuous get AIDS.
3. Donating blood can result in AIDS.
4. Casual contact such as touching, sneezing, having a meal with/sharing eating utensils with someone who has AIDS, and sharing a bathroom or going to the same school with a person with AIDS can transmit the virus.
5. AIDS can be transmitted through saliva, sweat, and tears.
6. Alcohol and drugs do not increase the risk of contracting AIDS.

strategic planning. This contributes to the development of a program that is acceptable to the community and yet meets the educational needs of the adolescent. When talking with community members about AIDS, it is important to correct their misunderstandings by providing the most current and accurate information. It is important to use statistics that speak specifically to the community in which the counselor is working. Communities, families, and individuals, confused or anxious about AIDS, deserve the help of professionals versed in handling the struggles surrounding this sensitive issue.

Many national, state, and local resources provide current information. A list of these resources is provided at the end of this chapter. To become an advocate who will be effective in addressing the AIDS and adolescents issue in your community, the following steps are suggested:

1. *Create an AIDS resource center for adolescents in your school, agency, or community.* The center should provide articles, pamphlets, books, and lists of local resources. Contact health departments, existing centers in other communities, or AIDS hotlines to find out what is available. Invite reputable guest speakers to discuss the social and medical aspects of AIDS and their effect on families and adolescents. Such speakers may be contacted through existing AIDS organizations and health departments in each community. The resources and informational talks provided by the center typically are appropriate not only for adolescents and their families, but also for any professional staff that would benefit from continuing education.

TABLE 4

AIDS Curricula: Sexual Decision-Making Model

Effective sexual decision-making skills need to be taught in terms of a larger frame of personal values. The exercise below is one example of a decision-making model for adolescents.

Check any of the reasons listed below that you used in deciding to become involved in a specific sexual behavior:

_____ I wanted to find out what it felt like.
_____ I was sexually excited.
_____ I wanted to be as experienced as my friends are.
_____ I was talked into it.
_____ I didn't really decide—it just sort of happened.
_____ I felt it would make me feel more mature or adult.
_____ My partner and I decided we were ready for it.
_____ I felt it was about time I tried it.
_____ My parents said it would be okay.
_____ Other: ________________________________

Check any of the reasons listed below that you used in deciding not to participate in a specific sexual behavior:

_____ I was scared.
_____ I didn't really like the person.
_____ My parents would disapprove.
_____ I wasn't sure how to do it.
_____ I don't believe people my age should be doing that.
_____ I wanted to wait until I was in love.
_____ I was afraid of getting caught.
_____ My partner wouldn't agree to it.
_____ I was afraid of getting venereal disease.
_____ I was afraid of getting AIDS.*
_____ I was afraid it would result in pregnancy.*
_____ Other: ________________________________

From *About Your Sexuality* (p. 19) by D. Calderwood. © 1983, Boston: Beacon Press. Adapted by permission.
*Entries by chapter authors.

2. *Voice concern to officials of organizations about the need to develop policies about AIDS and adolescents.* Schools, businesses, and government agencies have developed, or are in the process of developing, policies and procedures on AIDS. Offer your opinions regarding the special needs of adolescents to any organization that should be concerned

TABLE 5

AIDS Curricula: Sexual Communication Skills

Effective sexual communication skills are critical. Listed below are several areas that need to be talked about with a prospective partner prior to a sexual relationship.

1. Feelings.
2. Significance of the sexual encounter.
3. Sexual preferences and needs.
4. Birth control methods.
5. Safer sex plans.

with the AIDS issue. This may involve writing or speaking to legislators, school board members, presidents of corporations, and other officials.

3. *Support adolescents with AIDS and their families*. In many cases, individuals have been mistreated by friends and families after being diagnosed with AIDS. Some have been denied medical and social services. As a mental health professional it is necessary to be supportive and understanding when listening to each individual's worries and needs. Communicate to everyone concerned that one does not contract AIDS through casual contact, and that touching and emotional support are critical for the adolescent with AIDS.

4. *Develop awareness of AIDS resources in your community and encourage and support the implementation of additional needed resources*. The health care needs of those with AIDS are placing severe pressures

TABLE 6

AIDS Curricula: Safer Sex Plans

Sexually active adolescents might be encouraged to consider this current safer sex protocol. These guidelines are conservative and are presented as a framework that can be negotiated and modified to meet the particular needs of each individual adolescent.

1. Talk with prospective partner about sexual history.
2. Consider taking the HIV antibody test if sexual history warrants.
3. Commit to a monogamous relationship.
4. Refrain from exchange of bodily fluids for 6 months if there have been previous sexual contacts.
5. After 6 months use a condom with spermicidal jelly nonoxynol-9 when engaging in activities where there is exchange of bodily fluids.
6. Be informed about what specific sexual behaviors are dangerous, risky, less risky, safer, and safe.

on the health care system. It is important to know what resources exist in your community and to assist in the development of needed services. By assisting in fund-raising drives, starting a local AIDS support group, or calling local resources to see what is lacking, the counselor can promote the well-being of the adolescent population in the community. This active participation encourages others to become involved in providing much needed community support services.

The Counselor as Therapist

For the counselor as therapist, there are two broad adolescent groups that warrant attention. The first group includes two populations: adolescents whose behavior is curently high risk, and teenagers who may be concerned and anxious but whose behavior is not high risk. (This second population is often referred to as the "worried-well.") The second group includes adolescents who have AIDS. In addition to being knowledgeable in all the aspects of AIDS and sexuality that were previously defined for the counselor in the roles of sex educator and networker/advocate, the therapist needs to consider incorporating the following guidelines into the counseling session:

1. Provide information about AIDS to youth and their families.
2. Address the difficulties of implementing safer sex plans.
3. Respond to the emotional and psychological confusion surrounding sexual behaviors.
4. Incorporate exploration about sexual decision making.
5. Utilize counseling techniques such as role-play so that the client can rehearse discussing sexual behavior with prospective partners.
6. Assist the adolescent client in exploring personal sexual values in order to come to terms with similarities and differences between self and family of origin.
7. Refer the adolescent client to community resources for assistance with problems related to being concerned about AIDS.

Hypothetical Dialogue With a Worried-Well Youth

The following are sections of a hypothetical case dialogue between a school counselor and an adolescent. The above guidelines are incorporated into the responses to the client.

1. *Information*

Client: I saw on television last night this show about people dying from AIDS. I'm sure glad I'm not gay.

Counselor: I'm glad that you are concerned. However, AIDS is not a disease of only the gay population; anyone can get AIDS. If a person is sexually active, they need to protect themselves by using condoms. (The counselor could provide a pamphlet with more information about AIDS and teens.)

2. *Safer sex plan*

Client: Forget it, I'm not using condoms . . . they are too stupid.

Counselor: At first it is hard to use condoms. What is stupid about them for you? (The counselor and client could then discuss safer sex practices, keeping in mind that the less behavior the counselor asks a client to change, the more likely the behavior change is to occur. The key question is: "What is the least amount of change that you can make that will protect you from being at risk for AIDS?")

3. *Emotional confusion*

Client: I know that I shouldn't be sleeping with Pam, but it feels so good to be held.

Counselor: All of us need to be touched. If sex is making you feel bad, are there other ways you can be close to Pam? (A discussion might follow of the confusion that often exists between emotional closeness and sexual activity.)

4. *Decision making*

Client: Some of the boys don't put up with a girl who doesn't go all the way. I don't know what to do because I have heard so much about AIDS.

Counselor: Making these decisions is not easy. It would be great if there were a right answer that I could give you. What is most important is to help you decide which sexual activities feel comfortable and right for you. (The counselor might want to use the decision-making model included in this chapter.)

5. *Sexual values*

Client: My mom thinks that I shouldn't be Johnny's friend because she says he's a "homo." But, I like him better than any of the other kids in my class.

Counselor: It sounds like you and your mom have a difference in values. Sometimes people that we care about believe differently than we do. (This might lead into a discussion of values and self-confidence.)

6. *Referral*

Client: I don't know quite how to tell you this, but I am worried that I might have AIDS. Last week I slept over at Jim's house and we messed around.

Counselor: I appreciate your honesty. I have the name of a community clinic that kids can go to and get more information about AIDS.

Everything there is kept confidential. Would you like to talk more about your concerns?

Counseling Diagnosed Youth

Counseling the AIDS-diagnosed youth takes sensitivity and skill. The youth who has AIDS is facing a life-threatening illness, inevitable death, and stigmatization by some individuals in society. The client is likely to be confused about the medical aspects of the disease and guilt-ridden about past sexual experiences or drug use. The emotional responses of the client will also include fear, anger, denial, pain, and regret.

The specific guidelines suggested in Table 7 are one model of how to work with the adolescent with AIDS. It is important to remember that the suggested steps are not linear, and emphasis depends on the individual client and the relationship with that particular client. The therapeutic issues center around helping clients find the personal strength to cope with the remainder of their life. One of the most important aspects of counseling with the dying is a therapist's willingness to just "be there." The therapist is not able to take the pain or loss away from the clients. It is their pain and they will suffer it. Over and over again, dying persons indicate they fear being abandoned (Kalish, 1981). Because people with AIDS are frequently abandoned by loved ones and stigmatized by society, it is particularly important to interact with the client with great compassion, consistency, and genuineness. Without these fundamental dimensions, the following steps become empty rhetoric.

Case Study of an AIDS-Diagnosed Youth

The following is an example of how the therapist might begin to respond to an AIDS client like Joshua, the 17-year-old who was introduced at the beginning of this chapter. The guidelines from Table 7 are used as the framework for the therapist's responses.

Joshua is a frail, yet bright-eyed, 17-year-old White adolescent who was diagnosed with AIDS 3 months ago. He currently lives with his family. The initial counselor-client contact took place in the home upon recommendation of his physician. His parents are confused, yet supportive of his need for counseling. His presenting problem was: "Please help me—I don't want to die."

TABLE 7

Guidelines for Counseling the AIDS-Diagnosed Youth

A. Assessing
  1. Degree of medical illness
  2. Degree of psychological stress
  3. Degree of social isolation—support systems
  4. Significant others and family responses
  5. Management of daily living
  6. Financial need

B. Educating
  1. Effects of the virus
  2. Awareness of health care issues
  3. Transmission of the virus
  4. Sexual expression options

C. Assisting
  1. Networking with social agencies
  2. Employment and housing needs and discrimination
  3. Developing support systems

D. Counseling
  1. Providing an emotionally caring atmosphere
  2. Confronting denial about the AIDS diagnosis
  3. Confronting rejection and stigma issues
  4. Addressing loss and grieving issues surrounding death
  5. Teaching stress identification and reduction techniques

E. Advocating
  1. Social
  2. Political
  3. Legal

Joshua is the oldest of five children. He has three brothers aged 15, 14, and 12 and one sister aged 11. All members of the family have been active members of the Catholic church and the children attend Catholic schools. Father is 45 years old and works in middle management in a high-tech corporation. Mother is 43 years old and works part-time as a librarian in the state library. Joshua describes a history of happy family vacations and frequent outings until his preteen years. More recently the family has experienced financial stress and subsequent withdrawal of father due to more time spent at work. In the absence of his father Joshua has taken over the role of second parent to the younger children. The family members seem to operate more independently from one another than in the past.

Joshua was a well-liked student in high school until his diagnosis. His friends have been abusive to him and have not visited with him since his diagnosis. He was active in sports and extracurricular activities. He dated frequently and had occasional sexual contact; Joshua had many female friendships prior to his diagnosis. Approximately 1 year ago, accompanied by two peers, Joshua had a sexual encounter with two prostitutes.

Joshua's grades ranged between C+ and B−. He had started his senior year of high school, but due to negative community reaction was not able to finish the first semester after his diagnosis became public. Joshua used to work part-time at the library, but has been unable to work because of his illness.

Joshua had no significant medical history other than normal childhood illnesses prior to his diagnosis. Currently, he is recovering from a bout of pneumocystis pneumonia after spending 2 weeks in the hospital. He is still on medication for the pneumonia. Over the past 6 months he has lost 52 pounds. He is now at home and improving each day, though he currently weighs only 86 pounds. He has not been able to go outside the home for over a month.

Joshua seemed agitated, restless, and was unable to make eye contact for long periods of time. During the initial contact with the counselor he was teary-eyed, admitted great fear, and expressed confusion and helplessness. He struggled to maintain his composure throughout the session. He was reluctant to talk about his sexual history, though he seemed willing to relate other information about his past. He expressed bitterness toward his family and friends for abandoning him.

Therapist's Response

Assessing. Joshua is seriously ill but it can be expected that he will soon go into remission and feel better for periods of time. His psychological stress is high; his core issues seem to be fear of death and abandonment as well as guilt about his sexual contact(s). Currently, his support systems are not strong. However, possibilities for support exist from the parental dyad, from siblings, and from former friends. The theme of responses to Joshua are rejection and helplessness. Joshua's daily needs are being met. He currently is receiving consistent health care, and his basic living needs are being provided by his parents. The family's financial situation prior to the illness was tenuous and is further stretched by the high medical costs associated with AIDS.

Educating. It is important that Joshua, his family, and other individuals who are part of his system understand the cycle of AIDS and its related infections. The family and Joshua need accurate information about the effects of the medication so that they can distinguish between the medical effects and the symptoms of the infections associated with AIDS. If he and others are educated about the course of the virus, they will be able to make the most of the times when he is feeling better. Because there is a connection between the body's physiological responses and health habits, it is imperative that he eat and sleep well. Joshua and his family and friends need to have accurate information about how the HIV virus is transmitted. In particular, they need to understand the myths about AIDS transmission through casual contact. One reason for Joshua's rejection may be due to this kind of misinformation.

Assisting. It will be essential to work with community agencies that can provide outside assistance for Joshua. These include the local AIDS project and the county and state health departments. Frequently, support groups exist for persons with AIDS, and volunteers are available to help with transportation and other practical needs. This kind of intervention would give Joshua opportunities to leave the house occasionally. The issues of medical expenses for the family and future hospitalization also need to be addressed through the appropriate agencies. The counselor might need to get involved in outreach contacts to the other boys who also had sexual contact with the prostitute. It is likely that these adolescents are anxious and worried about contracting AIDS themselves.

Efforts need to be made to help Joshua continue his part-time employment at the library, even if in a more limited way. This might include arranging for Joshua to be allowed to bring library work home to do. The school needs to be contacted and a plan initiated so Joshua can continue in his high school program. The special services of the school district should be identified and contacted. Tutoring to assist Joshua to gain his high school diploma may be a viable option.

Joshua's primary, although not fully functioning, support system is his family. Family meetings should be held to work with the withdrawal patterns of his brothers and sister, the distancing of his father, and the helplessness of his mother. It might be important for the family to understand the caretaker role Joshua played as oldest sibling in the family, and the possible fear of family members associated with the prospect of losing that caretaker. The parents in particular will need to come to terms with the stigma associated with having a child who has AIDS. The family members must be assisted in recognizing the critical part they can play in supporting Joshua.

Other potential support systems are the many female friends Joshua had and athletic teammates at school. These two groups would need special outreach efforts to reestablish positive relationships.

Counseling. In starting a counseling relationship with Joshua, the counselor must be emotionally caring and supportive. The first step in the process is to assist Joshua in expressing his emotions in a safe and nonjudgmental setting. Joshua is experiencing denial and anger and must eventually be confronted with these issues in a facilitative manner. In order to confront Joshua about these issues it is essential to create a trusting bond. The pain associated with abandonment and rejection by his family and friends must be processed. The counselor can help Joshua begin to face his death by encouraging him to grieve and deal with his many losses. Because research has suggested that increase in the stress level exacerbates the rate of HIV-related infections, the therapist is obligated to teach stress identification and stress reduction techniques. If at all possible, it is important for the counselor to continue the therapeutic relationship with Joshua until his death.

Advocating. As in the landmark case of Ryan White (who contracted AIDS as a child from blood transfusions and was not allowed to continue enrollment in school in Kokomo, Indiana), Joshua may need social, political, and legal advocacy to help him fight the likely social injustices that affect adolescents with AIDS. The counselor needs to be proactive with all of the community agencies to ensure that Joshua receives the care and treatment to which he is entitled. It is imperative that the counselor take the necessary action and contact various agencies such as social security, legal aid, and the schools.

Ethical Issues in Counseling With the AIDS Client

The development of AIDS and the resulting deaths raise several professional questions for the counselor. A primary concern is confidentiality limits with the AIDS client who continues to be sexually active without informing his or her partner. The question that has recently been debated is: "At what point, if any, do counselors breach a confidential relationship with a client who has the AIDS virus to preserve society's goals of health and safety?" (Gray & Harding, 1988, p. 219). Limits of confidentiality in the counseling relationshp have previously been defined in terms of "clear and imminent danger" (American Association for Counseling and Development [AACD], 1988, Section D.4) to self or others, ordinarily seen in the context of client suicide and homicide.

Ethical standards do not precisely define what is clear and imminent danger. Therefore, the counselor does not necessarily know when it is appropriate to take responsibility for the client and break confidentiality. Clients who have AIDS and continue to be sexually active without informing their sexual partner(s) present a dilemma for professionals. Counselors are currently debating this controversy over the limits of confidentiality. However, the ethical standards do obligate the counselor to consult with other professionals whenever possible. Counselors who find themselves struggling with the conflict between confidentiality guidelines and clear and imminent danger guidelines should consult with other professionals as a part of their decision-making process.

Gray and Harding (1988) suggested that as a last resort when working with uncooperative clients, the therapist directly notify known sexual partners. With unknown sexual partners, these authors suggest that counselors consult with public health authorities and use state-identified procedures for responding to a client behaving dangerously. This ethical dilemma highlights the fine line between individual freedom and the health and welfare of society at large. There is no dominant legal precedent to look to for guidance on this issue, and it is likely that statutes will vary from state to state. Frequently statutes are at odds with ethical guidelines. This presents yet another complication for the therapist working with the adolescent who is not informing partners of his or her AIDS diagnosis.

Working With the Special Needs of Harder-to-Reach Youth

Whereas adolescents within the mainstram of the school system can benefit from traditional school-based AIDS education, adolescents outside the system need to be reached through specially targeted programs. The harder-to-reach adolescent often is the poor student, the drug abuser, the gay youth, and the minority teen. Adolescents in these groups are frequently kicked out of their homes because their family doesn't have money to support them or because their parents cannot handle them. They drop out of school, run away, and end up as street kids. About 30% of all students will drop out of high school before graduation, and more than one million teenagers run away each year (Center for Population Options as cited in Hersch, 1988). These runaways are escaping stressful environments and most often are victims of dysfunctional families. It is a myth that adolescents run away to seek adventure and excitement.

> 36 percent run from physical and sexual abuse; 44 percent from other severe long-term crises such as drug abusing, alcoholic parents or stepfamily crisis; and 20 percent from short-term crisis such as divorce, sickness, death, and school problems. . . . Approximately 70 percent of the runaways who come to the emergency shelters have been severely physically abused or sexually molested. (Hersch, 1988, p. 31)

Street kids have been labeled the "throwaways." These adolescents are sexually active with many people. It is a way to fight loneliness, satisfy curiosity, and survive hunger and homelessness. They are at increased risk for AIDS by virtue of lack of information regarding HIV infection, high level of drug use, and resorting to prostitution to earn money. HIV screening on these "throwaway" youth shows that approximately 48% have positive test results ("Throwaway Youths," 1988).

A recent figure indicates that an overwhelming number, over 200,000 teenagers, are involved in prostitution (Center for Population Options as cited in Hersch, 1988).

> They go home and sleep with their [old] friends, they sleep with their parents, they sleep with each other—there is hardly anybody they don't sleep with. And, of course, they sleep with their johns, who sleep with their wives and who also may be sleeping with their kids and their secretaries. (Able-Peterson as cited in Hersch, 1988, p. 35)

Gay men are currently and have always been the number one high risk group for AIDS in the United States. It is generally thought that 10% of the adult population is gay; that means 1 out of every 10 children in a classroom will eventually identify as gay (Heron, 1983). The gay youth is constantly pressured into a male-female life-style by a society that assumes everyone is heterosexual. It is not surprising that gay youth have become one of the biggest subgroups that make up the street kid phenomenon. The pain and fear of struggling with sexual identity creates a lonely world not often shared with anyone. If the adolescents' gay orientation is known, they often lose their family and peer group support system.

Counselors must challenge their own heterosexual assumptions. They must make a conscious effort to look for the children in the classroom who are grappling with sexual identity issues. It is important to listen to these children in a nonjudgmental fashion and help them find support in their struggle. The counselor must help the gay youth face two major issues: isolation and rejection by family. Through proactive and supportive interventions, such as acknowledgment that homosexuality is an acceptable life-style, it may be possible to meet the needs of these children. Consequently, this may prevent some from becoming runaways.

The minority teen is also at high risk for contracting AIDS, as indicated by the percentage of Blacks and Hispanics who have been diagnosed. The minority youth needs special attention and educational efforts. According to DiClemente et al. (1988):

> Black and Latino adolescents demonstrate a greater likelihood of perceived susceptibility. The prevalence of misconceptions about the threat of casual contagion of AIDS among Black and Latino adolescents suggests the need for preventive AIDS education not only to decrease potential high-risk behaviors, but also to reduce unnecessary feelings of anxiety regarding susceptibility. (p. 57)

Conventional programs discussed in the curricula section earlier in this chapter will not be effective for the harder-to-reach youth. For example, many of the conventional educational programs are not written in the language of the minority group. Emphasis needs to be placed on outreach programs that move outside of the classroom and into the streets. Counselors must be creative and develop programs using whatever methods work to reach these teenagers. If the kids can't come to counselors, counselors must go to the kids. Workers from programs for runaway children in New York City cruise the streets until 5:00 a.m. each morning offering hot chocolate, sandwiches, and condoms. The language counselors use may need to be changed. Terms such as intercourse and oral sex may need to be thrown out the window for "fucking" and "sucking." Along with professionalism, the therapist must bring his or her own "street smarts" when talking to the kids if high risk behavior for AIDS is going to be changed.

The Counselor as Referral Agent

The process of referral can be used in a variety of circumstances. The first may be when the counselor recognizes that his or her own biases and values are interfering with delivering appropriate services. At this time it is critical for the counselor to make the referral in a manner that does not negatively affect the adolescent with AIDS or the adolescent who has concerns about AIDS. A second reason for referral may arise when a problem is so specialized that it requires unique assistance that the counselor cannot provide. A third reason for referral is when a professional deems that his or her training and background are not appropriate to address the issue of AIDS.

It is important for the mental health professional to be familiar with existing resource lists or how to find them. In general, national helping professional organizations provide guidance for locating appropriate resources. The Center for Population Options (1012 14th Street, N.W., Suite 1200, Washington, DC 20005, (202) 347-5700) is a primary AIDS and adolescents resource at the national level. The center provides bibliographies, curricular information, pamphlets, materials for parents, videos, and leader resources.

State and local professional organizations also provide direction. *Typically, state and community health departments have current information about AIDS and should be considered a major information source.* In addition, organizations that specifically focus on providing AIDS services are available in most large communities. Included in the appendix of this chapter is a list of national organizations specifically involved in responding to the AIDS epidemic, and an AIDS bibliography.

Future Directions

Researchers are currently struggling to acquire the information and medical technology needed to develop a cure for AIDS. The outlook for a cure in the near future is not optimistic; but, as this medical fight continues, counselors must be involved actively in the social, psychological, political, legal, and ethical ramifications of AIDS. Adolescents with AIDS have been labeled by some as the modern-day lepers. This severe social stigma placed on adolescents with AIDS cannot be tolerated.

Counselors have special talents that can contribute to changing the course of negative societal reactions and eventually the course of this epidemic. By working actively to provide education and therapeutic intervention, the helping professional can assist individuals and their families in coping with the ravages of this disease. It is critical to unite with social workers, psychologists, physicians, health care providers, researchers, lawyers, government workers, religious leaders, and civic groups to address all ramifications of AIDS.

Helping professionals are not powerless. The ability to help others change their behavior, and to provide and foster compassion and concern for those diagnosed with AIDS, places counselors in a position of great influence. Helping others to change high-risk behavior so that the rate of AIDS infection is slowed would be a legacy of counselors worth remembering.

In this chapter we have emphasized the importance of counselors, accepting the role of educator. Education means more than providing factual information. It would be a grave mistake to assume that factual information by itself translates into behavioral change. The counselor must be progressive and creative. We need to break through the adolescent myth of: "This won't happen to me." One way to do this is to challenge the misconception that only homosexuals and IV drug users contract AIDS.

It is of paramount importance to promote media that depict the danger to heterosexuals. When adolescents see a peer die they will begin to relate to the risk AIDS poses to all adolescents.

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Appendix 1

National Organizations Involved in AIDS Issues

AIDS Action Council, 729 Eighth Street S.E., Suite 200, Washington, DC 20003; (202) 547-3101. This national organization works with the federal government to create a sound national AIDS policy, and lobbies for funding of AIDS research and treatment. It represents more than 300 community-based organizations that provide direct services to people with AIDS.

American Association of Physicians for Human Rights (AAPHR), 2940 16th Street, Room 309, San Francisco, CA 94103; (415) 558-9353. AAPHR is a national organization of physicians and medical students that deals with medical issues affecting homosexual men and women. Although not specifically an AIDS organization, AAPHR releases position statements about AIDS issues such as national mandatory antibody testing, and airline discrimination against PWAs. It also runs a national referral service for physicians and patients.

American Foundation for AIDS Research (AmFAR), 5900 Wilshire Blvd., 2nd Floor—East Satellite, Los Angeles, CA 90036; (213) 857-5900; and 40 West 57th Street, Suite 406, New York, NY 10019; (212) 333-3118. AmFAR is a private, national not-for-profit organization providing funding for research into the cure, prevention, and treatment of AIDS. It also produces educational materials for the general public, medical and scientific professionals, and PWAs.

The American Red Cross, 17th and D Streets N.W., Washington, DC 20006; (202) 737-8300. (Consult your phone book for your local chapter.) The objective of the American Red Cross is to slow the spread of AIDS through information and education that encourages responsible behavior. It provides training and educational materials for minorities and the general public for use in schools and the workplace, as well as other forms of support to people with AIDS, their families, and people testing HIV-positive. Contact your local chapter, not the national office, for these materials.

Computerized AIDS Information Network (CAIN), a service of the Gay and Lesbian Community Service Center, 1213 N. Highland Ave., P.O. Box 38777, Hollywood, CA 90038; (213) 464-7400, Ext. 277. This computer database provides AIDS information to subscribers 24 hours a day. The network receives 5,000 articles each month; the information is constantly updated. Listings in CAIN are free of charge. The network also allows people with AIDS to communicate with one another anonymously via computer.

Mothers of AIDS Patients (MAP). P.O. Box 3132, San Diego, CA 92103; (619) 293-3985 or (619) 576-6366. MAP was started by three mothers who lost children to AIDS. It offers emotional support to families of people with AIDS, provides information about the disease, and assists people with AIDS who have been rejected or are isolated from their families. It gives referrals and support by phone or mail.

National AIDS Network (NAN). 2033 M Street, N.W., Suite 80, Washington, DC 20036; (202) 293-2437. The National AIDS Network consists of community-based AIDS organizations, hospitals, and educational facilities. It provides technical assistance, referral services, and grants to its member organizations.

National Association of People With AIDS. 2025 Eye Street, N.W., Suite 415, Washington, DC 20006; (202) 429-2856. NAPWA is an association of local organizations by and for people with AIDS. It is based on the philosophy of self-empowerment. The association provides information and referrals to its member organizations and also advocates for rights for people with AIDS. It has more than 60 affiliates, and over 6,000 members.

National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). P.O. Box 239, Milwaukee, WI 53201; (414) 277-7671. The coalition was established to encourage information exchange among gay STD and AIDS service providers; its members are primarily health care professionals. Funds are raised through membership dues and subscriptions to its publication.

National Council of Churches AIDS Task Force. 475 Riverside Dr., Room 572, New York, NY 10115; (212) 870-2421. Preventive education is the focus of this group. It has compiled a resource and information packet for use by religious leaders in their congregations.

National Leadership Coalition on AIDS. 1150 17th Street, N.W., Suite 202, Washington, DC 20036; (202) 429-0930. More than 100 corporations, businesses, and religious, labor, trade, and health organizations make up this coalition, which seeks to increase public and private sector cooperation on AIDS issues. It is working especially to improve the response of employers and employees to AIDS, and to encourage balanced and informed consideration of public policies concerning the disease.

Appendix 2

Annotated Bibliography

Advice for Life: A Woman's Guide to AIDS Risks and Prevention. Chris Norwood. Pantheon Books. ISBN 0-394754-28-X. $7.95. Discusses transmission, symptoms, and personal prevention by explaining high-risk activities and which men may be at high risk for AIDS. Also addresses "the caring woman" and her role in the epidemic, and the future of AIDS.

AIDS: A Catholic Call for Compassion. Eileen P. Flynn. Sheed & Ward. ISBN 0-934134-73-1. $4.95. Discusses AIDS from a Catholic perspective. Points the way beyond fear to reason and concern.

AIDS: The Facts. John Langone. Little, Brown. ISBN 0-316-51412-8. $8.95. Explains in clear, concise language how the AIDS virus works, how it is transmitted, and why, based on the latest scientific knowledge and statistics. Examines in detail all the methods presently under development for treatment, as well as the possibilities for a vaccine.

AIDS: Personal Stories in Pastoral Perspective. Earl E. Shelp, Ronald H. Sunderland, and Peter W. A. Mansell. Pilgrim Press. ISBN 0-8298-0739-X. $7.95. Provides information about AIDS, its effect on both patients and nonpatients, the response of society, and the obligation of the church.

AIDS: A Self-Care Manual. Betty Clare Moffatt et. al. IBS Press. ISBN 0-9616605-1-1. $12.95. A comprehensive self-care guide, created by the AIDS Project Los Angeles, that examines the many aspects of personal AIDS management. The manual is a valuable resource for people with AIDS and AIDS-related illnesses, as well as for health professionals, therapists, caregivers, ministers, medical writers, family members, spouses, co-workers—everyone touched by the AIDS crisis.

AIDS: The Spiritual Dilemma. John E. Fortunato. Harper & Row. $7.95. Encourages a spiritual response to society's victimizing attitude. Stresses the importance of a spiritual journey to help transcend the crisis.

AIDS: You Can't Catch It Holding Hands. Niki de Saint Phalle. Lapis Press. ISBN 0-932499-52-X. $6.95. This remarkable and unique book for children (or a charming book to dispel adults' fears and introduce them to the problem) provides a clear understanding of the latest information about AIDS, and refocuses our attention on the positive aspects of human relationships.

And the Band Played On: Politics, People and the AIDS Epidemic. Randy Shilts. St. Martin's Press. ISBN 0-312-00994-1. $24.95. By the time America woke up to the dangers of the AIDS epidemic with the revelations of Rock Hudson's affliction, the disease had spread to every corner of the nation. America faced troubling questions: What went wrong? Although not without its errors in fact, this is a book that will astound and enrage any American.

Borrowed Time: An AIDS Memoir. Paul Monette. Harcourt Brace Jovanovich. ISBN 0-15-113498-3. $18.95. The extraordinary love story of two men battling AIDS together. Newsweek calls it "a powerful account of shattering eloquence."

Confronting AIDS: Directions for Public Health, Health Care and Research. Institute of Medicine/National Academy of Sciences. National Academy Press. ISBN 0-309-03699-2. $24.95. A committee with an impressive breadth of credentials was established to prepare this in-depth report. Although often technical, much information is of importance to lay audiences interested in helping to combat the epidemic.

Epidemic of Courage: Facing AIDS in America. Lon G. Nungesser. St. Martin's Press. ISBN 0-312-01560-7. $7.95. The author, who himself has AIDS, talks with seven PWAs about the impact the disease has had on their lives. He goes on to talk with a lover, a mother, a brother, a health care provider, and a friend about the crises they've suffered while working with and loving PWAs.

Living With AIDS: Reaching Out. Tom O'Connor. Corwin Publications. ISBN 9-93856-00-7. $18.95. O'Connor looks at how people with AIDS and ARC can improve the quality of their lives—even prevent further immune deterioration—and how those who test positive for the AIDS antibody can keep the prospect of disease at bay.

Making It: A Woman's Guide to Sex in the Age of AIDS. Cindy Patton and Janis Kelly. Sparks/Firbrand Books. ISBN 0-932379-32-X. $3.95. Two AIDS activists and journalists address a critical question: How can women—heterosexual, lesbian, bisexual—enjoy full sexual lives and protect themselves from AIDS? Pro-sex in tone, often humorous, with information on safe sex, pregnancy, testing, and drug use in both English and Spanish.

Night Kites. M.E. Kerr. Harper & Row. ISBN 0-694-05616-2. $2.75. A novel for young adults about a 17-year-old whose well-ordered life begins to fall apart as he keeps secret his brother's diagnosis with AIDS. How people hide, betray, accept, and love is sensitively explored in this novel.

Questions and Answers on AIDS. Lyn Frumkin and John Leonard. Avon Books. ISBN 0-380-75467-3. $3.95. Straightforward, practical advice on AIDS: what causes it, how it is transmitted, and the treatments presently available. A good introductory book on the subject.

Safe Sex: The Ultimate Erotic Guide. John Preston and Glenn Swann. Plume/NAL. ISBN 0-452-25896-0. $8.95. A certified sexual health consultant, John Preston, and "Mr. Safesex," Glenn Swann, offer the reader an explicit program of safe sexual practices for gay men and everyone concerned about AIDS.

Screaming Room. Barbara Peabody. Avon Books. ISBN 0-380-70345-9. $3.95. A mother's journal of her son's struggle with AIDS. A true story of love, dedication, and courage told with directness and feeling.

Serenity: Challenging the Fear of AIDS. Paul Reed. Celestial Arts. ISBN 0-89087-506-5. $5.95. Reed offers coping strategies that can help anyone who is struggling to find peace of mind, mental energy, and emotional balance in the midst of the pain and anguish that living with the AIDS epidemic can bring.

Sex, Drugs and AIDS. Oralee Wachter. Bantam Books. ISBN 0-553-3445-4. $3.95. Based on the 18-minute award-winning film directed toward teenagers, this book dispels the myths of how AIDS is transmitted and provides young people with ways to safeguard themselves. Although written for teenagers, this is an excellent introductory book for anyone concerned about AIDS.

Someone Was Here: Profiles in the AIDS Epidemic. George Whitmore. New American Library. ISBN 0-4530-0601-9. $27.95. This gripping account of the AIDS crisis provides intimate, moving portraits of the people with AIDS, their loved ones, and their caretakers.

Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome. Marcia Quackenbush and Pamela Sargent. Network Publications. A guide for teachers that gives practical, straightforward advice on how to teach students about AIDS.

When Someone You Know Has AIDS: A Practical Guide. Leonard J. Martelli et al. Crown Publishers. ISBN 0-317-52879-3. $9.95. An informative, compassionate guide offering realistic advice about everything from fear and grief to health insurance and wills. How do you manage the medical, legal, and financial issues? Where do you find organizations that will offer support? This practical guide is used by a number of social service organizations.

Appendix 3

A Phone Directory of Local and State Organizations

This listing, compiled with the cooperation of the National AIDS Network, will help you get started if you want to volunteer your time to an AIDS group in your community. This is not a complete listing of AIDS organizations, but the groups listed here can tell you about other organizations in your area. In addition to these groups, your local, county, or state health department often can be helpful.

Phone numbers in italics are hotlines offering general information about AIDS, referrals, and sometimes counseling. Other listings are general office numbers.

ALABAMA
Birmingham: AIDS Outreach, *205-930-0440; 800-445-3741*
Mobile: AIDS Buddy Program, 205-476-9142;
AIDS Coalition, 205-344-5684
Montgomery: AIDS Outreach, 205-284-2273
Tuscaloosa: West Alabama AIDS Network, 205-345-0067

ALASKA
Anchorage: Alaska AIDS Project, 907-276-4880; *800-478-AIDS*

ARIZONA
Phoenix: Arizona AIDS Project, *602-277-1929*
Tucson: AIDS Project, *602-322-6226; 602-326-AIDS*

ARKANSAS
Little Rock: ARK. AIDS Foundation, 501-224-4020; *501-374-5503*

CALIFORNIA
Bakersfield: AIDS Task Force, *805-328-0729*
Berkeley: Gay Men's Health Collective, 415-644-0425
Campbell: Aris Project, 408-370-3272
Concord: Diablo V Community Church, *415-827-2960*
Fresno: Central Valley AIDS Team, 209-264-2437
Garden Grove: AIDS Response Program, *714-534-0862*
Guerneville: Face to Face, 707-887-1581
Irvine: Buddhist AIDS Project, 213-859-5536
Long Beach: Project Ahead, 213-439-3948
Los Angeles: AIDS Project, 213-380-2000; 213-876-AIDS
Merced: AIDS Support Team, 209-385-7709

Modesto: Stanislaus Community AIDS Project, 209-572-2437
Oakland: AIDS Project of the East Bay, 415-420-8181
Palm Springs: Desert AIDS Project-CCCC, Inc., 619-323-2118
Redding: North State AIDS Project, 916-225-5252
Sacramento: AIDS Foundation, 916-448-2437
San Diego: AIDS Assistance Fund, 619-543-0300;
    AIDS Project, 619-543-0300
San Francisco: AIDS Foundation, 415-864-4376, *800-FOR-AIDS*,
    Shanti Project, 415-777-2273
San Luis Obispo: AIDS Task Force, 805-549-5540
Santa Barbara: Tri-Counties AIDS Project, 805-681-5120
Santa Cruz: AIDS Project, 408-458-4999
Santa Rosa: Sonoma County AIDS Project, 707-527-2247
West Hollywood: AIDS Project, 213-876-8951;
    Shanti Foundation, 213-273-7591

COLORADO

Denver: Colorado AIDS Project, 303-837-0166

CONNECTICUT

Bantan: N.W. Conn. AIDS Project, 203-482-1596; *203-567-1111*
Hartford: Gay/Lesbian Health Collective, 203-236-4431
New Briton: AIDS Project, 203-225-7634; 203-225-6789
New Haven: AIDS Project, 203-624-2437

DELAWARE

Wilmington: Delaware Lesbian and Gay Health Advocates AIDS Co.,
    302-652-6776

DISTRICT OF COLUMBIA

Washington: Whitman Walker Clinic, 202-332-5295

FLORIDA

Daytona Beach: DARE, 904-257-4028
Ft. Lauderdale: AIDS Center One, 305-561-0316; *800-325-5371*
Key West: AIDS Help Inc., 305-296-6196
Lakeland: Polk AIDS Support Service, 813-665-7071
Miami: Health Crisis Network, 305-326-8833; *305-634-1636*
Orlando: Cent. Fla. AIDS Unified Resources Inc., 305-849-1452
Sarasota: AIDS Support, 813-951-1551
Tampa: AIDS Network, 813-221-6420; 813-221-6420

GEORGIA

Athens: AIDS Support Group, 404-546-0737
Atlanta: AIDS Atlanta, 404-872-0600; *800-551-2728*
Macon: Central City AIDS Network, 912-742-2437
Savannah: First City Network, Inc., 912-236-CITY

HAWAII

Honolulu: Life Foundation, 808-924-2437
Kailua: Hawaii Council of Churches, 808-263-9788
Volcano: AIDS Helpline, 808-967-7202

IDAHO

Boise: Idaho AIDS Foundation, 208-345-2277

ILLINOIS

Belleville: Helping Hands of So. Ill., 618-234-9365
Champaign: Champaign AIDS, 217-351-2437
Chicago: AIDS Education Project, 312-908-9191;
AIDS Foundation, 312-525-9466

INDIANA

Evansville: AIDS Resource Group, 812-423-7791
Fort Wayne: AIDS Task Force, 219-484-2711
Indianapolis: AIDS Task Force, 317-634-1441

IOWA

Des Moines: Cent. Iowa AIDS Project
Iowa City: Iowa Center for AIDS/ARC Education, 319-351-0140
Waterloo: AIDS Coalition of Northeast Iowa, 319-234-6831

KANSAS

Topeka: Kansas AIDS Network, 800-247-4101;
AIDS Project, 913-232-3100
Witchita: AIDS Project, 316-267-1852

KENTUCKY

Lexington: AIDS Crisis Taskforce, *696-281-5151*
Louisville: Comm. Health Trust, 502-636-3341

LOUISIANA

Baton Rouge: MCC-AIDS Project, 504-387-4424
New Orleans: NO/AIDS Task Force, 504-891-3732

MAINE

Portland: AIDS Project, 207-774-6877

MARYLAND

Baltimore: H.E.R.O., 301-685-1180
Rockville: Montgomery County HERO, 301-762-3385
Silver Spring: African Center AIDS Project, 301-622-0129

MASSACHUSETTS

Boston: AIDS Action, 617-437-6200
Brighton: Project Win, 617-783-7300
Cambridge: AIDS Family Support Group, 617-491-0600

MICHIGAN

Detroit: AIDS Phone Network, 313-567-1640
Ferndale: PWA Food Bank, 313-864-3740
Grand Rapids: AIDS Task Force, 616-956-9009
Hamtramck: Friends, People With AIDS Alliance, 313-365-2450

MINNESOTA

Minneapolis: Minn. AIDS Project, 612-870-7773

MISSISSIPPI

Jackson: Mississippi Gay Alliance, 601-353-7611

MISSOURI

Columbia: MID Missouri AIDS Project, 314-875-2437
Kansas City: Good Samaritan Project, 816-561-8784
Springfield: AIDS Project/Springfield, 417-864-8373
St. Louis: Effort For AIDS, 314-531-2847

MONTANA

Billings: AIDS Support Network, 406-252-1212

NEBRASKA

Omaha: Nebraska AIDS Project, 402-342-4233
Project Concern/AIDS Coalition, 402-455-3701

NEVADA

Las Vegas: Aid for AIDS of Nevada, 702-369-6162
Reno: Nevada AIDS Foundation, 702-329-2437

NEW HAMPSHIRE

Concord: New Hampshire Buddy System, 603-880-6560
Manchester: N.H. AIDS Foundation, 603-880-6560

NEW JERSEY

Neptune: AIDS Information Group, 201-758-0077
New Brunswick: AIDS Education, 201-992-5666
Newark: N.J. Lesbian & Gay AIDS Awareness, 201-596-0767
Randolph: Interfaith AIDS, 201-895-4874
Vineland: Casa Prac, Inc., 609-692-2331

NEW MEXICO

Albuquerque: New Mexico AIDS Services, 505-266-0911

NEW YORK

Albany: AIDS Council, 518-434-4686
Bridgehampton: East End Gay Org., 516-537-2480
Bronx: Pediatric AIDS Hotline, 212-430-4227
Brooklyn: AIDS Task Force C.S.P., 718-596-4781
Buffalo: Western N.Y. AIDS Prog. 716-847-2441
Johnson City: So. Tier AIDS Program, Inc., 607-798-1706
New York: Gay Men's Health Crisis, 212-807-6604
Richmond Hill: AIDS Center, 718-575-8855
Rochester: AIDS Rochester, Inc., 716-232-3580
White Plains: Mid-Hudson Valley AIDS Task Force, 914-993-0606

NORTH CAROLINA

Asheville: Western N.C. AIDS Project, 704-252-7489
Charlotte: Metrolina AIDS Project, 704-333-2437
Durham: Lesbian & Gay Health Project, 919-683-2182
Greensboro: Triad Health Project, 919-275-1654
Greenville: Eastern Regional AIDS Support, 919-355-4568
Raleigh: AIDS Control Program, 919-733-7301
Wilmington: Grow AIDS Resource Project, 919-675-9222
Winston-Salem: AIDS Task Force, 919-723-5031

OHIO

Akron: AIDS Task Force, 216-375-2960
Canton: AIDS Task Force, 216-489-3231
Cincinnati: Ambrose Clement Health Clinic, 513-352-3139
Cleveland: Health Issues Task Force, 216-621-0766
Columbus: AIDS Task Force, Inc., 419-243-9351
Youngstown: AIDS Task Force, 216-742-8700

OKLAHOMA

Oklahoma City: Oasis Community Center, 405-525-AIDS

OREGON

Eugene: Willamette AIDS Council, 503-345-7089
Portland: Cascade AIDS Project, 503-223-5907
Oregon AIDS Task Force, 503-226-6678

PENNSYLVANIA

Allentown: AIDS Service Center, 215-435-4616
Altoona: AIDS Intervention Proj., 814-946-5411
Chester: American Red Cross, 215-874-1484
Harrisburg: So. Central AIDS Assistance Network, 717-236-4772
Lancaster: AIDS Project, 717-394-3380; 717-394-9900
Philadelphia: Action AIDS, 215-732-2155;
AIDS Task Force, 215-545-8686
Pittsburgh: AIDS Task Force, 412-363-6500
Reading: Berks AIDS Health Crisis, 215-375-2242
Scranton: North East AIDS Council, 717-342-4562

RHODE ISLAND

Providence: Project AIDS, 401-277-6545

SOUTH CAROLINA

Columbia: Carolina AIDS Research and Education, 803-777-2273

SOUTH DAKOTA

Sioux Falls: Sioux Empire Gay & Lesbian Coalition, 605-332-4599

TENNESSEE

Chattanooga: Chattanooga Cares, 615-265-2273
Knoxville: AIDS Response, 615-523-2437
Memphis: Aid to End AIDS Committee, 901-454-1411
Nashville: Nashville Cares, 615-385-1510

TEXAS

Austin: AIDS Services, 512-458-AIDS
Dallas: AIDS Resource Center, 214-521-5124
El Paso: SW AIDS Committee, 915-533-6809, 915-541-4266
Houston: AIDS Foundation, 713-623-6796
San Antonio: AIDS Foundation, 512-733-1853

VERMONT

Burlington: Vermont Cares, 802-863-2437

VIRGINIA

Charlottesville: AIDS Support Group, 804-979-7714
Norfolk: Tidewater AIDS Crisis Taskforce, 804-423-5859
Richmond: AIDS Information, 804-355-4428

WASHINGTON

Seattle: Northwest AIDS Foundation, 206-329-7923;
AIDS Action Committee, 206-323-1229

WISCONSIN

Milwaukee: AIDS Project, 414-273-2437

Chapter 11

"I DON'T WANT TO LIVE": SUICIDAL BEHAVIOR

Dave Capuzzi and Douglas R. Gross

The adolescent at risk for suicidal preoccupation and behavior has become an increasing concern for schools and communities throughout the United States. The topic of adolescent suicide has been a major focus for newspaper features, television specials, and legislative initiatives as the problem of adolescent suicide has reached epidemic proportions (Hafen & Frandsen, 1986). Estimates such as "7,000 teenagers each year commit suicide, while an additional 400,000 try unsuccessfully to end their own lives" (Hafen & Frandsen) are based on incomplete data (Curran, 1987) yet provide the basis for ranking suicide as the second leading cause of death among the 11-to-24 age group. According to some experts (Hafen & Frandsen), one teenager attempts suicide every 90 seconds and one completes the act of suicide every 90 minutes.

Understanding the Causes

The Adolescent Transition

Adolescence as a stage in psychosocial development has become more complex, more stressful, and more prolonged than ever before. Choices about whether to use drugs, to join gangs, to experiment sexually, or to pursue a vocational or academic course of study must be made earlier and earlier amidst escalating pressure and confusing options. These choices prove to be difficult even for adolescents who are successfully mastering the essential developmental task of separation and identity formation. These developmental tasks can occur only, however, when children and adolescents have been exposed to positive adult models for parenting and nurturing. As adults become increasingly focused on earning a living in a country in which the cost of food, clothing, housing, medical care, and other necessities has increased more rapidly than salaries, less time may be available for parenting roles. In addition, adolescents become disillusioned when political and religious luminaries (e.g., Dan Quayle, John Tower, Jim and Tammy Bakker) lose credibility because of their behavior or societal prejudice. Traditional values may seem questionable and increasing emphasis on education, which lengthens preparation time for jobs or careers that may not provide the quality of life enjoyed by today's adults, may make it even harder for adolescents to develop needed perspective. For some adolescents the use and abuse of alcohol and other substances, running away, dropping out of school, developing eating disorders, sexual acting out, and other at-risk behaviors may be connected with the need to lower stress and may be preludes to increased vulnerability for a suicide attempt or completion.

Family Dysfunctions

As mentioned earlier, the transition from childhood to adolescence and young adulthood is difficult at best. A stable, functional family can provide the support and the role modeling to make such a transition easier. Many theorists and researchers (Bigras, Gauthier, Bouchard, & Tasse, 1966; Jacobziner, 1965; McAnarney, 1979; Otto, 1972; Tuckman & Connon, 1962; Capuzzi & Golden, 1988) discuss family dysfunction as a characteristic of the family of a suicidal adolescent. Events such as divorce, death, unemployment, or moving are frequent occurrences in American families that must be dealt with in a way that promotes problem solving and good communication. Individuals in functional family systems can usually make the adjustments necessary to cope constructively with changes in the family. Members of dysfunctional families, however, usually experience high stress during periods of transition.

A number of patterns can be observed in dysfunctional families that can affect an adolescent's vulnerability to depression and suicidal preoccupation (Capuzzi, 1986).

Poor communication skills. In most families of adolescents who have attempted or completed suicide, communication between parents or between parents and children (and usually both) has not been optimal. Family members may have difficulty describing their thoughts and their feelings or be uneasy about sharing them even if they are able to articulate accurately. Usually the parents in such a family (one or both) have not been able to role model well for their children; indeed, the parents may not have experienced positive role modeling in their families of origin.

Parents may have been taught to suppress self-expression or may have been subjected to bursts of anger with little explanation or description provided. Children and adolescents usually do not attain communication levels higher than those of their parents. They may be unable or afraid to express themselves, and parents may have little awareness of the tribulations an adolescent son or daughter experiences. Often, families do not have time to share with one another, or they make such opportunities difficult because the attention of family members is directed toward a television show, a newspaper, or music even when they are all together.

Resistance to the grieving process. Loss is something that requires a grieving and adjustment process that passes through a series of phases or stages. The dissolution of the family of origin because of death or a divorce, changes in health status or job security, or moves to new housing or a new community require major psychological adjustments and changed perspectives. It is important to integrate and later reframe such experiences in a way that can lead to new beginnings and changed life-styles. Often suicidal adolescents come from families that have experienced losses and in which individual family members have resisted the need to grieve and denied the range of feelings that accompany the grieving process. Such a family can become even more dysfunctional and can increase the vulnerability of family members who already experience difficulty coping on a daily basis. Such families may not realize the need to grieve and the universality of such a need. They may not understand the range of feelings they are experiencing and attempt to deny or distort the experience and the events connected with it.

Difficulties with single parenting. The role of the single parent in American society is difficult. Escalating responsibility, lowered income, high stress, and lack of time are only a few examples of the kinds of problems a single parent may encounter. It is difficult for even the most functional of adults to cope with the parameters of raising a child (or children) without the emotional support and financial assistance a partner can provide. There may be little time for relaxation, fun, and positive verbal encounters in the life of a single parent who is having great difficulty coping with expectations and obligations. Parent-child-relationships in such a situation are bound to be impaired, and a troubled single parent is likely to be faced with a troubled adolescent.

Confusion in a blended family. When two adults who have custody of the children from a previous marriage decide to form a new family, the dynamics of the family constellation can become complex. For some adolescents, it is too difficult to adjust to a "substitute" parent for the one lost through a divorce, a new set of guidelines for behavior and discipline, additional siblings, and less personal space or a different home in a new neighborhood or community. Parents may need to arrange for family counseling when adolescent children show signs of depression and poor adjustment to the new family group.

Midlife transition stressors. Adolescence, particularly early adolescence, is a time of rapid psychological and physical change. Many parents do not realize that their adolescent children are being called upon to cope with changes as numerous and as rapid as the changes these children experienced during the first year of life. Parents may not realize that they need to spend as much or more time with their children than ever before because adolescent children look more like young adults than children in need of support, structure, and guidelines. Because parents of adolescents are usually between the ages of 35 and 50, they may be focused on assessing themselves as personalities, as partners, as career achievers, and as income providers. Often such parents, particularly parents whose own dysfunctions inhibit their perspective and their parenting abilities, fail to understand the needs of their adolescent children and do not provide the time and the structure and stability so necessary for optimal family functioning. Such parents may be too focused on their own status and too apprehensive about time "running out" to respond to the needs of their adolescent sons and daughters. It is usual for middle-aged adults to assess their satisfactions as well as their disappointments; this process, however, cannot be so consuming that members of the family lack the nurturance and psychological bonding so necessary for the rites of passage that take an adolescent successfully into the next stage of young adult development.

Abusive interactions. Families in which physical or sexual abuse is occurring or in which substance abuse is problematic may be at high risk for adolescent suicide. Parents who are abusive of each other, themselves, or their children are typically low in self-esteem, stressed, poor communicators and problem-solvers, and financially distressed. Children of such parents have not been taught to feel good about themselves and to solve problems well. During adolescence, escaping the pain of such a family atmosphere or the self-deprecating viewpoint they have probably developed may become adolescents' most predominating motivation for suicide.

Environmental Pressures

Academic achievement. Schools and families often pressure their adolescent students/children to emphasize scholarly pursuits at the expense of developing relationships, hobbies, and pastimes that provide enjoyment and balance to release stresses and renew energy. Even good students can be the recipients of pressure, threats, and admonitions to achieve spiraling levels of achievement and excellence. When adolescents whose identify is too aligned with school-related pursuits develop anxiety over the need for continued performance, some may become preoccupied with suicide as a means to escape increasing pressures. Death may seen preferable to the possibility of failing and the threat of not meeting expectations.

Constant mobility. Although a reasonable amount of change and mobility can be renewing and energizing, too much mobility can provide the basis for isolation, loneliness, and alienation. Often mobility is mandated because of career opportunities, divorce, or a desire to improve environmental circumstances. Unfortunately, too much movement can result in depression and exhaustion. Some groups, such as those living in the central or rapidly changing portions of a city, immigrants, and families working for large companies (McAnarney, 1979) may not be able to exercise enough control over mobility demands. Such demands can make it extremely difficult for adolescents' families to cope and adjust.

High school completion. Graduating from high school is an important transition or "rite of passage" for most adolescents. High school graduation symbolizes the end of childhood and the beginning of independence and young adulthood. Young people are "expected" to take more initiative in the process of further developing autonomy and independence from their families of origin. Options for employment, further education, military service, marriage, and other areas must all be considered; choice points are complex and decisions can have both long- and short-term effects. Even though many adolescents register emphatic complaints about the requirements connected with progression through and graduation from secondary education and "proclaim" the joys of high school completion, most adolescents experience a great deal of stress about the future. Suddenly, they will no longer be with peers they may have seen daily for years; the post-high school environment may be completely new and lack the "structure" secondary schools provide. Adolescents already at risk for suicide may be even more vulnerable prior to and after graduation because their stress levels may further impair decision making, coping, and adjustment relative to the myriad changes and transitions they will experience.

Availability of drugs. Most fifth and sixth graders in the United States can access the use of illicit drugs. Opportunities to experiment with alcohol, marijuana, and other drugs are common, and often young people are pressured by their peers to participate and threatened with expulsion from the group if they refuse. Many vulnerable upper-elementary school children and early adolescents mistake or confuse their involvement with the drug culture as something that can enhance their feelings of well-being and autonomy. Because problem-solving ability, self-esteem, or communication skills, which may already be inadequate, are never enhanced through the use of drugs, suicide-prone adolescents usually become even higher risks as drug experimentation and dependency increase. Parents often do not recognize either the profile of the drug-abusing adolescent or that of the suicidal adolescent, and the situation may progress to the point of a crisis prior to intervention of any kind. Often schools do not have prevention, crisis management, or postvention programs and services related to either suicide prevention or drug abuse. Though communities may express concern and request diagnostic, counseling, and related services, school boards often refuse to fund necessary services and voters do not support increased taxes.

The world community. Today's young people are completely aware of the fact that no nation or component of the world community can be totally independent or safe from the actions, and the results of those actions, of another country. The economic choices, military decisions, election results, environmental problems, treaties, and other events all affect the quality of life in communities around the world. The nuclear accident in Chernobyl, for example, and the resultant radioactive fallout experienced around the world lends reinforcement to the fact that no one can be safe from a nuclear detonation no matter how far the distance. Some adolescents cite these observations as reasons for considering suicide.

Intervention Strategies

Negotiating With Administrators

There is a compelling need for prevention, crisis management, and postvention programs for the adolescent suicide problem to be put in place in elementary, middle, and high schools throughout the country. Based on the experience of these authors in the process of working with school districts all over the country, one of the biggest mistakes of counselors, educators, and coordinators of counseling/student services is to initiate programs and services in this area without first obtaining commitment and support of administrators and others in supervisory positions. Too often efforts are initiated and then cancelled because little or no negotiation with those in decision-making positions has taken place. Building principals must be supportive; otherwise all efforts are destined for failure. Developing understanding of the parameters connected with suicide prevention and intervention must start with the building principal and extend to all faculty and staff in a given building so that advance understanding of why quick action must take place is developed. During a crisis schedules must be rearranged and faculty and staff may be called upon to teach an extra class, assist with an initial assessment, and so forth. Everyone connected with a given building must have advance preparation.

In addition to the groundwork that must be done on the building level, it is also important to effect advance communication and planning at the district level. The superintendent, assistant superintendent, curriculum director, staff development director, student services coordinator, research and program evaluation specialist, and others must all commit their support to intervention efforts. When administrators have the opportunity to listen to an overview of proposed efforts and ask questions, a higher level of commitment can be established and efforts can be more easily expedited. The probability of extending proposed programming to all schools in a given district is also increased.

Faculty/Staff Inservice

Because teachers and other faculty and staff usually learn of a student's suicidal preoccupation prior to the situation being brought to the attention of the school counselor or another member of the core or crisis team (assuming such a team exists), *all* faculty and staff must be included in building or district-level inservice on the topic of adolescent suicide. Teachers, aides, secretaries, administrators, custodians, bus drivers, food service personnel, librarians, school social workers, and others all come in contact with adolescents at risk for suicide. It is imperative that all such adults be educated about both adolescent suicide and building and district policies and programs for prevention, crisis management, and postvention. When a young person reaches out to a trusted adult, that adult must have a clear understanding and a considerable amount of self-confidence so he or she knows exactly what to say and do as well as what not to say and do.

Many schools and school districts have actually precipitated suicide attempts by not providing for faculty/staff inservice on the topic prior to introducing discussion among student groups. When middle and high school students participate in educational programs on the topic of adolescent suicide, they begin to realize that they, as well as some of their friends, are at risk, and they approach admired adults for assistance. Adults in the school who have no knowledge of what to do and who have not had the opportunity to have their questions answered and their apprehension lowered may be threatened by what a student is sharing and fail to make appropriate comments and decisions. Highly stressed, depressed suicidal adolescents do not have the perspective to realize that such responses are connected with discomfort on the part of the adult and have little to do with what could be interpreted as disapproval and lack of acceptance. Awkward and minimal responses to suicidal self-disclosure on the part of a trusted adult can be interpreted as the loss of the last link to society and provide additional reinforcement for finalizing a suicide plan.

IT IS UNETHICAL NOT TO PREPARE SCHOOL FACULTY AND STAFF IN ADVANCE OF THE PRESENTATION OF INFORMATION ON SUICIDE TO THE STUDENTS IN A SCHOOL. TO DO SO COULD ALSO BECOME THE BASIS FOR LEGAL ACTION BY PARENTS AND FAMILY MEMBERS. The content for necessary inservice will be presented later in this chapter.

Preparation of Crisis Teams

Many schools have "crisis" or "core" teams composed of faculty, staff, and parents connected with a particular building. These teams often exist in conjunction with a program for the prevention and intervention efforts necessary to cope with the drug problem among the young people in today's schools. Such teams usually consist of some combination of teachers, counselors, parents, social workers, school psychologists, school nurses, and school administrators. Usually these teams have been educated about traits that place adolescents at risk for substance use and abuse and have had supervision and instruction on the use of appropriate communication, diagnostic, and intervention skills necessary to begin the long-term process of recovery from alcoholism and other addictions. With education beyond what is provided during the faculty/staff inservice discussed previously as well as additional supervision and evaluation of clinical skills, a "core" or "crisis" team can be taught how to facilitate prevention efforts in a school as well as how to respond to a student already experiencing a suicidal crisis or in need of postvention efforts. In addition, such a team can be expected to write a policy statement that covers all parameters connected with prevention, crisis management, and postvention efforts. Such a policy could be adopted in other schools; in reality, except for specifics connected with a given building, the same policy statement should be adopted and followed throughout a school district. It is important to realize that everyone who is called upon to assist a suicidal adolescent must know what to do. Confusion or lack of certainty about a chain of command or procedures for notifying parents can result in delays and interfere with efforts to save a young person's life!

Individual and Group Counseling Options

Prior to providing students with any information about suicide and suicide prevention efforts in a school, arrangements must be made for the individual and group counseling services that will be needed by those who seek assistance for themselves or their friends. Unless such counseling options are available, any effort at prevention, crisis management, or postvention will be doomed to failure. This may present a problem to school personnel, particularly on the secondary level, unless there is a commitment on the part of administrators to free counselors from scheduling, hall monitoring, and other duties unrelated to the emerging role of the counselor of the 1980s and 1990s. Working with suicidal adolescents requires a long-term commitment on the part of those interested in intervening. No counselor, psychologist, or social worker can undo the experiences and self-perceptions of a lifetime without providing consistent, intensive opportunities for counseling.

If the school district cannot make a commitment to providing counseling, then arrangements for referral to community agencies and private practitioners must be made. It is important to provide adolescents and their families with a variety of referral possibilities along with information on fee schedules. There may be some question about whether the school district will be liable for the cost of such counseling if the referral is made by the school. (This issue should be explored by whatever legal counsel is retained by the district.) The dilemma, of course, is that unless counseling takes place when a suicidal adolescent has been identified, the probability is high that an attempt or a completion will take place. If the school is aware of a teenager's suicidal preoccupation and does not act in the best interests of such a teenager, families may later bring suit against the district. (This issue will be further discussed later in this chapter.)

Parent Education

Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school's efforts to educate, identify, and assist young people in this respect. Parents have a right to understand why the school is taking such steps and what the components of a schoolwide effort will be like. Evening or late afternoon parent education efforts can be constructive and engender additional support for a school or school district. Parents have the same information needs as faculty and staff with respect to the topic of adolescent suicide. They will be more likely to refer themselves and their children to the school for assistance if they know of the school's interest in adolescent suicide prevention, have had an opportunity to ask questions about their adolescent sons' and daughters' behavior, and have been reassured about the quality and safety of the school's efforts.

Classroom Presentations

Debate about the safety of adolescent suicide prevention programs containing an educational component that is presented to adolescents continues. This debate is similar to the one that emerged 10 or 15 years ago when schools initiated staff development and classroom presentations on the topic of physical and sexual abuse. There are a number of advocates of education and discussion efforts that are focused on students in conjunction with a schoolwide suicide prevention effort (Capuzzi, 1986; Capuzzi & Golden, 1988; Curran, 1987; Ross, 1980; Sudak, Ford, & Rushforth, 1984). Providing adolescents with an appropriate forum in which they can receive accurate information, ask questions, and learn about how to obtain help for themselves and their friends does not precipitate suicidal preoccupation or attempts (Capuzzi, 1988). Because newspaper and television reports of individual and cluster suicides do not usually include adequate education on the topic, and because many films have unrealistically presented or romanticized the act of suicide, it is important for schools to address the problem in a way that provides information and encourages young people to seek help prior to reaching the point of despair. A carefully planned and well-presented classroom presentation by a member of the school's crisis team (or another presenter who has expertise on the topic) is essential. Such a presentation should include both information on causes, myths, and symptoms, as well as information about how to obtain help through the school. *Under no circumstances should media be used in which adolescents are shown a suicide plan.* In addition, on the elementary level, school faculty should not present programs on the topic of suicide prevention; their efforts are better focused on developmental counseling and classroom presentations directed at helping children overcome traits (such as low self-esteem or poor communication skills) that may put them at risk for suicidal behavior at a later time. Although these efforts should be continued through secondary education, middle and high school students are better served through presentations that address adolescent suicide directly. (Middle and high school students almost always have direct or indirect experience with suicide and appreciate the opportunity to obtain information and ask questions.)

Staff Development Efforts

As discussed earlier, it is unethical to initiate a suicide prevention effort in any context unless the adults who come in contact with adolescents have been prepared in advance. Generally, it takes a minimum of 2 full days to prepare teachers and other staff to play their roles in a total school program for suicide prevention. Additional time is required for preparation of core or crisis teams and for development of a written plan of action for suicide prevention, crisis management, and postvention. Some schools prefer that everyone obtain 2 full days of staff development on the topic; others provide 1 day for the entire faculty and staff and the second day only for members of the core or crisis teams.

The purpose of such inservice efforts is to sensitize each adult to the problem of adolescent suicide and the school's role in intervention so that each adult can identify those at risk and provide support in the process of referring students for help to the school counselor and other members of core or crisis teams. Under no circumstances are faculty and staff to attempt to provide the counseling or assessment services that can only be offered by someone with appropriate expertise. All adults in a setting in which preventive education is presented to adolescents must, at a minimum, understand the myths, the profile of the potential attempter, and the guidelines for making referrals.

The following information will provide the reader with ideas about the content of inservice education for faculty and staff. Because of length limitations for this chapter, it is not possible to provide the content for a comprehensive "curriculum." Moreover, the material should not be used by someone who is not a qualified school or mental health professional because of the questions participants in such inservice groups ask about suicidal dynamics, diagnosis, and the counseling/therapy process.

Understanding the Myths

It is important to disqualify myths and misconceptions about adolescent suicide at the beginning of any initiative to provide prevention, crisis management, and postvention services. Some of the most commonly cited misconceptions include the following (Capuzzi, 1988).

Adolescents who talk about suicide never attempt suicide. This is probably one of the most widely believed myths. All suicidal adolescents make attempts (either verbal or nonverbal) to let a friend, parent, or teacher know that life seems to be too difficult to bear. Because a suicide attempt is a cry for help to identify options, other than death, to decrease the pain of living, always take verbal threats seriously. Never assume such threats are only for the purpose of attracting attention or manipulating others. It is better to respond and enlist the aid of a professional than it is to risk the loss of a life.

Suicide happens with no warning. Suicidal adolescents leave numerous hints and warnings about their suicidal ideations and intentions. Clues can be verbal or in the form of suicidal gestures such as taking a few sleeping pills, becoming accident-prone, reading stories focused on death and violence, and so forth. Often the social support network of the suicidal adolescent is small. As stress escalates and options, other than suicide, seem few, suicidal adolescents may withdraw from an already small circle of friends, making it more difficult for others to notice warning signs.

Adolescents from affluent families attempt or complete suicide more often than adolescents from poor families. This, too, is a myth. Suicide is evenly divided among socioeconomic groups.

Once an adolescent is suicidal, he or she is suicidal forever. Most adolescents are suicidal for a limited period of time. In the experience of the authors, the 24–72 hour period around the peak of the "crisis" is the most dangerous. If counselors and other mental health professionals can monitor such a crisis period and get the adolescent into long-term counseling/therapy, there is a strong possibility the adolescent will never have another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during this postsuicidal crisis period and the more time that passes, the better the prognosis.

If an adolescent attempts suicide and survives, he or she will never make an additional attempt. There is a difference between an adolescent who experiences a suicidal crisis but does not attempt suicide, as in the example above, and the adolescent who actually makes an attempt. An adolescent who carries through with an attempt has identified a plan, has had access to the means, and has maintained a high enough energy level to follow through. He or she may believe that a second or third attempt may be possible. If counseling/therapy has not taken place or has not been successful during the period following an attempt, additional attempts may be made. Most likely, each follow-up attempt will become more lethal.

Adolescents who attempt or complete suicide always leave notes. Only a small percentage of suicidal adolescents leave notes. This is a common myth and one of the reasons why many deaths are classified and reported as accidents by friends, family members, physicians, and investigating officers when suicide has actually taken place.

Most adolescent suicides happen late at night or during the predawn hours. This myth is not true for the simple reason that most suicidal adolescents actually want help. Mid to late morning and mid to late afternoon are the time periods when most attempts are made because a family member or friend is more likely to be around to intervene than would be the case late at night or very early in the morning.

Never use the word suicide when talking to adolescents because using the word gives some adolescents the idea. This is simply not true; you cannot put the idea of suicide into the mind of an adolescent who is not suicidal. If an adolescent is suicidal and you use the word, it can help the adolescent verbalize feelings of despair and assist with establishing rapport and trust. If a suicidal adolescent thinks you know he or she is suicidal and realizes you are afraid to approach the subject, it can bring the adolescent closer to the point of making an attempt by contributing to feelings of despair and helplessness.

Every adolescent who attempts suicide is depressed. Depression is a common component of the profile of a suicidal adolescent but it is not always a component. Many adolescents simply want to escape their present set of circumstances and do not have the problem-solving skills to cope more effectively, lower stress, and work toward a more promising future.

Suicide is hereditary. Suicide tends to run in families, just as physical and sexual abuse does, and has led to the development of this myth. Suicide is not genetically inherited. Members of families do, however, share the same emotional climate because parents model coping and stress-management skills as well as a level of high or low self-esteem. The suicide of one family member tends to increase the risk among other family members that suicide will be viewed as an appropriate way to solve a problem or set of problems.

In conjunction with this myth, it should be noted that endogenous depression can be inherited. Because of the connection between depression and suicide, many have mistakenly come to the belief that suicide can be genetically inherited.

Recognizing the Profile

A number of experts (Capuzzi & Golden, 1988; Curran, 1987; Davis, 1983; Hafen & Frandsen, 1986; Hussain & Vandiver, 1984; Johnson & Maile, 1987) believe that about 90% of the adolescents who complete suicide (and lethal first attempts can result in completions) give cues to those around them in advance. Whether these cues or hints are limited or numerous will depend on the adolescent because each adolescent has a unique familial and social history. It is important for adults (and young people as well) to recognize the signs and symptoms to facilitate intervention. A comment such as "I talked with her a few days ago and she was fine—I am so shocked to learn of her death" may mean that no one was aware of the warning signs. One of the essential components of any staff development effort is teaching the profile of the suicidal or potentially suicidal adolescent so that referral and intervention can take place. Behavioral, verbal, and cognitive cues, as well as personality traits, are the four areas described below.

Behaviors

Lack of concern about personal welfare. Some adolescents who are suicidal may not be able to talk about their problems or give verbal hints that they are at risk for attempting suicide. Sometimes such adolescents become unconcerned with their personal safety in the hopes that someone will take notice. Experimenting with medication, accepting "dares" from friends, reckless driving, carving initials into the skin of forearms and so forth may all be ways of "gesturing" or letting others know, "I am in pain and don't know how to continue through life if nothing changes."

Changes in social patterns. Relatively unusual or sudden changes in an adolescent's social behavior can provide strong cues that such a young person is feeling desperate. A cooperative teenager may suddenly start breaking the "house rules" that parents have never had to worry about enforcing. An involved adolescent may begin to withdraw from activities at school or end long-term friendships with school and community peers. A stable, easy-going teenager may start arguing with teachers, employers, or other significant adults with whom prior conflict was never experienced. Such pattern changes should be noted and talked about with an adolescent who does not seem to be behaving as he or she usually has in the past.

A decline in school achievement. Often adolescents who are becoming increasingly depressed and preoccupied with suicidal thoughts are unable to devote the time required to complete homework assignments and maintain grades. If such an adolescent has a history of interest in the school experience and has maintained a certain grade point average, loss of interest in academic pursuits can be a strong indication that something is wrong. The key to assessing such a situation is the length of time the decline lasts.

Concentration and clear thinking difficulties. Suicidal adolescents usually experience marked changes in thinking and logic. As stress and discomfort escalate, logical problem solving and option generation become more difficult. It becomes easier and easier to stay focused on suicide as the only solution as reasoning and thinking become more confused and convoluted. "It may become more and more obvious that the adolescent's attention span is shorter and that verbal comments bear little relationship to the topic of a conversation" (Capuzzi, 1988, p.6).

Altered patterns of eating and sleeping. Sudden increases or decreases in appetite and weight, and difficulty with sleeping or wanting to sleep all the time or all day, can indicate increasing preoccupation with suicidal thoughts. These altered patterns can offer strong evidence that something is wrong and that assistance is required.

Attempts to put personal affairs in order or to make amends. Often, once a suicide plan and decision have been reached, adolescents will make "last minute" efforts to put their personal affairs in order. These efforts may take a variety of directions: attempts to make amends in relation to a troubled relationship, final touches on a project, reinstatement of an old or neglected friendship, or the giving away of prized possessions (skis, jewelry, compact discs, collections, etc.).

Use or abuse of alcohol or drugs. Sometimes troubled adolescents use or abuse alcohol or other drugs to lessen their feelings of despair or discontent. Initially, they may feel that the "drug" enhances their ability to cope and to increase feelings of self-esteem. Unfortunately, the abuse of drugs decreases the ability to communicate accurately and solve problems rationally. Thinking patterns become skewed, impulse control lessens, and option identification decreases. Rapid onset of involvement with illicit or over-the-counter drugs is indicative of difficulty with relationships, problem solving, and ability to share feelings and communicate them to others.

Unusual interest in how others are feeling. Suicidal adolescents often express considerable interest in how others are feeling. Because they are in pain, but may be unable to express their feelings and ask for help, they may reach out to peers (or adults) who seem to need help with the stresses of daily living. Such responsiveness may become a full-time pastime and serve to lessen preoccupation with self and to serve as a vehicle for communicating, "I wish you would ask me about my pain" or "Can't you see that I need help too?"

Preoccupation with death and violence themes. Reading books or poetry in which death, violence, or suicide is the predominant theme can become the major interest of an adolescent who is becoming increasingly preoccupied with the possibility of suicide. Such adolescents may be "undecided" about the possibility of choosing death over life and may be working through aspects of such a decision with this reading. Other examples of such preoccupation can include listening to music that is violent, writing short stories focused on death, dying, and loss, drawing or sketching that emphasizes destruction, or watching movies that emphasize destruction to self and others.

Sudden improvement after a period of depression. Suicidal adolescents often fool parents, teachers, and friends by seeming to be dramatically improved shortly after a period of prolonged depression. This improvement can sometimes take place overnight or during a 24-hour period and encourages friends and family who interpret this change as a positive sign. It is not unusual for a change of this type to be the result of a suicide decision and the formulation of a concrete suicide plan on the part of the adolescent at risk. It may mean that the suicide attempt (and the potential of completion) is imminent and that the danger and crisis are peaking. The important point for family and friends to remember is that it is not really logical for a depression to lessen that rapidly. It takes time, effort, and, at times, medical assistance, to improve coping skills and lessen feelings of depression just as it took time (months or years) to develop nonadaptive responses to people and circumstances and feelings of hopelessness.

Sudden or increased promiscuity. It is not unusual for an adolescent to experiment with sex during periods of suicidal preoccupation in an attempt to refocus attention or lessen feelings of isolation. Unfortunately, doing so sometimes complicates circumstances because of an unplanned pregnancy or an escalation of feelings of guilt.

Verbal Cues

As Schneidman, Farbverow, and Litman (1976) noted, verbal statements can provide cues to self-destructive intentions. Such statements should be assessed and considered in relation to behavioral signs, changes in thinking patterns, motivations, personality traits, and so forth. There is no "universal" language or "style" for communicating suicidal intention. Some adolescents will openly and directly say something like "I am going to commit suicide," or "I am thinking of taking my life." Others will be far less direct and make statements such as: "I'm going home," "I wonder what death is like," "I'm tired," "She'll be sorry for how she has treated me," or "Someday I'll show everyone just how serious I am about some of the things I've said."

The important thing for counselors, parents, teachers, and friends to remember is that when someone says something that could be interpreted in a number of ways, it is always best to ask for clarification. It is not a good idea to make assumptions about what a statement means or to minimize the importance of what is being communicated. Suicidal adolescents often have a long-term history of difficulty with communicating feelings and asking for support. Indirect statements may be made in the hope that someone will respond with support and interest and provide or facilitate a referral for professional assistance.

Thinking Patterns and Motivations

In addition to the areas previously described, thinking patterns and motivations of suicidal adolescents can also be assessed and evaluated. For such an assessment to occur, it is necessary to encourage self-disclosure to learn about changes in an adolescent's cognitive set and distortions of logic and problem-solving ability. As Velkoff and Huberty (1988) noted, the motivations of suicidal adolescents can be understood more readily when suicide is viewed as fulfilling one of three primary functions: (1) an avoidance function that protects the individual from the pain perceived to be associated with a relationship or set of circumstances; (2) a control function that enables an adolescent to believe he or she has gained control of someone or something thought to be out of control, hopeless, or disastrous; and (3) a communication function that lets others know that something is wrong or that too much pain or too many injuries have been accumulated.

Often suicidal adolescents distort their thinking patterns in conjunction with the three functions of avoidance, control, and communication so that suicide becomes, and remains focused on, as the best or only problem-solving option. Such distortions can take a number of directions. All-or-nothing thinking, for example, can enable an adolescent to view a situation in such a polarized way that the only two options seem to be continuing to be miserable and depressed or carrying out a suicide plan; no problem-solving options to cope with or overcome problems may seem possible (Capuzzi, 1988). Identification of a single event that is then applied to all events is another cognitive distortion, that of overgeneralization. Being left out of a party or trip to the mountains with friends may be used as "evidence" for being someone no one likes, a "loser," or someone who will always be forgotten or left out. "I can't seem to learn the material for this class very easily" becomes "I'm never going to make it through school," or "I'll probably have the same difficulties when I start working full time." Adolescents who are experiencing stress and pain and who are becoming preoccupied with suicidal thoughts often experience increasing cognitive distortions. Such distortions result in self-talk that becomes increasingly negative and supportive of one of the following motivations for carrying through with a suicide plan:

- Wanting to escape from a situation that seems (or is) intolerable (e.g., sexual abuse, conflict with peers or teachers, pregnancy, etc.);
- Wanting to join someone who has died;
- Wanting to attract the attention of family or friends;
- Wanting to manipulate someone;
- Wanting to avoid punishment;
- Wanting to be punished;
- Wanting to control when or how death will occur (an adolescent with a chronic or terminal illness may be motivated in this way);
- Wanting to end a conflict that seems unresolvable;
- Wanting to punish the survivors; and
- Wanting revenge.

Personality Traits

As Capuzzi (1988) noted, it would be ideal if the research on suicidal adolescents provided practitioners with such a succinct profile of personality traits that teenagers at risk for suicide could be identified far in advance of any suicidal risk. Adolescents who fit the profile could then be assisted through individual and group counseling and other means. Although no consensus has yet been reached on the "usual," "typical," or "average" constellation of personality traits of the suicidal adolescent, researchers have agreed on a number of characteristics that seem to be common to many suicidal adolescents.

Low self-esteem. A number of studies (Cull & Gill, 1982; Faigel, 1966; Stein & Davis, 1982; Stillion, McDowell, & Shamblin, 1984) have connected low self-esteem with suicide probability. The counseling experience of the authors, as well as the experience of other practitioners, seems to substantiate the relationship between low self-esteem and suicide probability. Almost all such clients have issues focused on feelings of low self-worth, and almost all such adolescents have experienced these self-doubts for an extended period of time.

Hopelessness/helplessness. Most suicidal adolescents report feeling hopeless and helpless in relation to their circumstances as well as their ability to cope with these circumstances. The research support (Cull & Gill, 1982; Kovacs, Beck, & Weissman, 1975; Jacobs, 1971; Peck, 1983) for verification of what clinicians report is growing. Most practitioners can expect to address this issue with suicidal clients and to identify a long-term history of feeling hopeless and helpless on the part of most clients.

Isolation. Many, if not most, suicidal adolescents tend to develop a small network of social support. They may find it uncomfortable to make new friends and rely on a small number of friends for support and companionship. This may be the reason why so often those around a suicide victim state they did not notice anything unusual. The suicidal adolescent may not be in the habit of getting close enough to others so that changes in behavior or outlook can be noted. A number of authorities (Hafen, 1972; Kiev, 1977; Peck, 1983; Sommes, 1984; Stein & Davis, 1982) seem to support this observation.

High stress. High stress, coupled with poor stress management skills, seems to be characteristic of the suicidal adolescent. A number of studies have addressed this trait in terms of low frustration tolerance (Cantor, 1976; Kiev, 1977).

Acting out. Behaviors such as truancy, running away, refusal to cooperate at home or at school, use or abuse of alcohol or other drugs, and experimentation with sex are frequently part of the pattern in the life of a suicidal adolescent. Such behaviors may be manifestations of depression. Often, adults remain so focused on the troublesome behavior connected with an adolescent's need to act out that underlying depressive episodes may be overlooked.

Need to achieve. Sometimes suicidal adolescents exhibit a pattern of high achievement. This achievement may be focused on getting high grades, being the "class clown," accepting the most "dares," wearing the best clothes, or any one of numerous other possibilities. In the counseling experience of the writers, this emphasis on achievement often is a compensation for feelings of low self-esteem. Readers should be cautioned, however, about jumping to the conclusion that every adolescent who achieves at a high level is suicidal. This trait, along with all the other traits and characteristics connected with the profile of the suicidal adolescent, must be assessed in the context of other observations.

Poor communication skills. Suicidal adolescents often have a history of difficulty in expressing thoughts and feelings. Such adolescents may have trouble with identifying and labeling what they are feeling; self-expression seems awkward if not stressful. It is not unusual to discover that adolescents who have become preoccupied with suicidal thoughts have experienced a series of losses or disappointments that they have never been able to discuss and, understandably, integrate or resolve.

Other-directedness. Most suicidal adolescents are "other" rather than "inner" directed. They are what others have told them they are instead of what they want to be; they value what others have said they "should" value instead of what they deem to be of personal value and worth. This trait may also be linked to low self-esteem and may lead to feelings of helplessness or inability to control interactions or circumstances around them.

Guilt. Usually connected with feelings of low self-esteem and a need to be other-directed, the guilt many suicidal adolescents experience is bothersome and sometimes linked to a "wanting to be punished" motivation for suicide. "Nothing I do seems to be good enough," or "I feel so bad because I disappointed them," or "I should not have made that decision and should have known better" are statements common to the guilt-ridden suicidal adolescent.

Depression. Depression is a major element in the total profile of the suicidal adolescent. Hafen and Frandsen (1986) pointed out that sometimes there are differences between depression in an adult and depression in an adolescent. Adults are often despondent, tearful, sad, or incapable of functioning as usual. Although adolescents sometimes exhibit these characteristics, they may also respond with anger, rebelliousness, truancy, running away, or using and abusing drugs. Those adults and peers who associate depression only with feelings of sadness and despondency may not recognize depression in adolescents who mask it with behavior that creates discomfort in a family and school environment.

As Capuzzi (1988) noted:

> Given the complexity of being an adolescent in the late 1980s, coupled with the normal ups and downs of the developmental stage of adolescence, it is normal for every adolescent to experience short periods of depression. But when depressive periods become more and more frequent, longer and longer, and of such intensity that the adolescent has difficulty functioning at school and at home, they could be a strong warning sign of suicide potential, especially if other aspects of behavior, verbalization, motivations and cognitive distortions have been observed. (p.10)

It is extremely important for counselors and other professionals who may be working with suicidal adolescents to complete additional coursework or training to learn about the different types of depression. Although familiarity with resources and guidelines such as those provided by McWhirter and Kigin (1988) and the *Diagnostic and Statistical Manual of Mental Disorders—Revised* (American Psychiatric Association, 1987) are readily available to mental health practitioners, case supervision and consultation may be needed to accurately determine the nature of a depressive episode. Frequently, well-meaning practitioners fail to discriminate between depression created by a constellation of factors (negative self-talk, poor problem-solving skills, high stress, etc.) and depression that is endogenous and a result of the body chemistry inherited at birth. Treatment or counseling plans are different based on the kind of depression experienced. Counselors, therapists, and core or crisis team members need to collaborate with nurse-practitioners and psychiatrists when medical assessment and subsequent medication are appropriate for endogenous depression.

Poor problem-solving skills. Most parents notice differences in the problem-solving ability of their children. Some children are more resourceful than others in identifying problem resolution options. Suicidal adolescents seem, in the experience of the writers, to have less ability to develop solutions to troublesome situations or uncomfortable relationships. This may be a reason why suicidal preoccupation can progress from a cognitive focus to an applied plan, with little dissonance created by the formulation and consideration of other problem-solving options and decisions.

Planning Prevention, Crisis Management, and Postvention Efforts

Staff development efforts should always include information about the prevention, crisis management, and postvention components that must be part of all "systems" efforts to intervene in the adolescent suicide problem. In school settings it is important for all faculty and staff to understand the importance of all three components, even though members of the core or crisis teams will be the individuals in the school who will carry out most, if not all, of the crisis management and postvention efforts.

Prevention

Most suicidal adolescents have developed their "at-risk" profiles over time, beginning during early childhood. In families with more than one child, it is often easy for parents to identify differences in self-esteem, communication skills, stress management, and problem solving. By the time a child is in elementary school, there may be visible indicators or traits that, if no intervention takes place, will result in the child's involvement in one or several at-risk behaviors. In the opinion of the authors, such a child, by the time the middle school or junior high transition occurs, will be vulnerable to becoming pregnant, contracting AIDS, abusing drugs, developing an eating disorder, dropping out, or attempting or completing suicide.

It is extremely important for counselors and other core team members in elementary schools to provide the mental health education and developmental counseling so necessary for prevention purposes. Although the authors do not recommend calling such efforts "suicide prevention" at the elementary level, it is important for school personnel to provide mental health education through classroom guidance sessions designed to help children overcome traits that put them at risk later in life. Programs focused on self-esteem enhancement, stress management, problem solving, understanding and communicating feelings, and so forth are of paramount importance. Such programming should be carefully and sequentially planned, and classroom teachers should be assisted with implementation and reinforcement efforts. In addition, small group counseling should be available for students who seem to need more assistance than that which can be provided in a classroom learning environment. Ongoing one-to-one counseling should also be made available for those in need of individual attention.

By the time young people are in middle or high school, they may have had contact with a peer who attempted or completed the act of suicide. In addition, most students of middle and high school age have been exposed to films as well as newspaper and television journalism highlighting the adolescent suicide problem. Because of the impact of one or a combination of the above factors, the authors believe that suicide prevention efforts at these levels should be labeled as such because students are usually candid with their questions and observations related to adolescent suicide. As noted earlier in conjunction with staff development efforts, it is critical that educational programs before classroom groups be carefully planned and rehearsed as well as delayed until such time as crisis, postvention, referral, and counseling services are in place. It is also important to continue with more generalized mental health education efforts as well as small group and individual counseling options.

Crisis Management

If an adolescent has been identified as potentially suicidal, every possible step should be taken to involve the adolescent in ongoing counseling so that preventive steps can be taken quickly and proactively. A number of cognitive-behavioral models have proven effective with depressed, suicidal adolescents. Albert Ellis (1979), John Krumboltz and Carl Thoresen (1976), and Arnold Lazarus (1976) have presented frameworks for counselors to use with such adolescents. Numerous films, filmstrips, and videos are available for classroom guidance presentations (Kidsrights, 1989). In addition, the American Association of Suicidology's journal, *The Journal of Suicide and Life Threatening Behavior*, is an excellent resource for professionals.

There are times, however, that adolescents at risk for suicide are not identified until a crisis state has been reached. In such circumstances, it is important for all concerned to initiate action to assess lethality and determine appropriate follow-up. Because many professionals who are not counselors lack experience with adolescents who are in the midst of a personal crisis, the following guidelines may prove helpful.

1. Remember the meaning of the term "crisis management." When thinking of crisis management, it is important to understand the meaning of the word "crisis" as well as the word "management." The word "crisis" means that the situation is not usual, normal, or average; circumstances are such that a suicidal adolescent is highly stressed and in considerable emotional discomfort. Adolescents in crisis usually feel vulnerable, hopeless, angry, low in self- esteem, and at a loss for how to cope. The word "management" means that the professional involved must be prepared to apply skills that are different that those required for preventive or postvention counseling. An adolescent in crisis must be assessed, directed, monitored, and guided for the purpose of preventing an act of self-destruction. Because adolescents who are experiencing a suicidal crisis may be volatile and impulsive, the need for decisive, rapid decision making on the part of the intervener is extremely important.

2. Be calm and supportive. A calm, supportive manner on the part of the intervener conveys respect for the perceptions and internal pain of an adolescent preoccupied with suicidal thoughts. Remember that such an adolescent usually feels hopeless and highly stressed. The demeanor and attitude of the helping person is pivotal in the process of offering assistance.

3. Be nonjudgmental. Statements such as "You can't be thinking of suicide, it is against the teachings of your church," or "I had a similar problem when I was your age and I didn't consider suicide" are totally inappropriate during a crisis situation. An adolescent's perception of a situation is, at least temporarily, real and that reality must be respected. The same caution can be applied to the necessity of respecting a suicidal adolescent's expression of feelings whether these feelings are those of depression, frustration, fear, or helplessness. Judgmental, unaccepting responses and comments serve only to further damage an already impaired sense of self-esteem and decrease willingness to communicate. Adolescents could sink further into depression or increase their resolve to carry through with a suicide plan if others are critical and unwilling to acknowledge what seem, to the adolescent, to be unsurmountable obstacles.

4. *Encourage self-disclosure.* The very act of talking about painful emotions and difficult circumstances is the first step in what can become a long-term healing process. A professional helper may be the first person with whom such a suicidal adolescent has shared with and trusted in months or even years, and it may be difficult to do simply because of lack of experience with communicating thoughts and feelings. It is important to support and encourage self-disclosure so that an assessment of lethality can be made early in the intervention process.

5. *Acknowledge the reality of suicide as a choice, but do not "normalize" suicide as a choice.* It is important for practitioners to let adolescents know that they are not alone and isolated with respect to suicidal preoccupation. It is also important to communicate the idea that suicide is a choice, a problem-solving option, and that there are other choices and options. This may be difficult to do in a way that does not make such an adolescent feel "judged" or "put down." "It is not unusual for adolescents to be so upset with relationships or circumstances that thoughts of suicide occur more and more frequently; this does not mean that you are weird or a freak. I am really glad you have chosen to talk to me about how you're feeling and what you are thinking. You have made a good choice because, now, you can begin exploring other ways to solve the problems you described" is an example of what could be said to an adolescent in crisis.

6. *Listen actively and reinforce positively.* It is important, during the initial stages of the crisis management process, to let the adolescent at risk for suicide know you are listening carefully and really understanding how difficult life has been. Not only will such careful listening and communicating, on the part of the professional, make it easier for the adolescent to share, but it will also provide the basis for a growing sense of self-respect. Being listened to, heard, and respected is a powerful and empowering experience for anyone who is feeling at a loss for how to cope.

7. *Do not attempt in-depth counseling.* Although it is very important for a suicidal adolescent to begin to overcome feelings of despair and to develop a sense of control as soon as possible, the emotional turmoil and stress experienced during a crisis usually makes in-depth counseling impossible. Developing a plan to begin lessening the sense of crisis an adolescent may be experiencing is extremely important, however, and should be accomplished as soon as possible. Crisis management necessitates the development of a plan to lessen the crisis; this plan should be shared with the adolescent so that it is clear that circumstances will improve. Counseling/therapy cannot really take place during the height of a suicidal crisis.

8. Contact another professional. It is a good idea to enlist the assistance of another professional, trained in crisis management, when an adolescent thought to be at risk for suicide is brought to your attention. School and mental health counselors should ask a colleague to come into the office and assist with assessment. It is always a good idea to have the support of a colleague who understands the dynamics of a suicidal crisis; in addition, the observations made by two professionals are likely to be more comprehensive. Because suicidal adolescents may present a situation that, if misjudged or mismanaged, could result in a subsequent attempt or completion, it is in the best interests of both the professional and the client for professionals to work collaboratively whenever possible. It should also be noted that liability questions are less likely to become issues and professional judgment is less likely to be questioned if assessment of the severity of a suicidal crisis and associated recommendations for crisis management have been made on a collaborative basis.

9. Ask questions to assess lethality. A number of dimensions must be explored to assess lethality. This assessment can be accomplished through an interview format (a crisis situation is not conducive to the administration of a written appraisal instrument). The following questions help determine the degree of risk in a suicidal crisis; all of them do not need to be asked if the interview results in the spontaneous disclosure of the information.

"What has happened to make life so difficult?" The more an adolescent describes the circumstances that have contributed to feelings of despair and hopelessness, the better the opportunity for effective crisis management. The process of describing stress-producing interpersonal situations and circumstances may begin to lower feelings of stress and reduce risk. It is not unusual for an adolescent in the midst of a suicidal crisis to describe a multifaceted set of problems with family, peers, school, and drugs. The more problems an adolescent describes as stress-producing and the more complicated the scenario, the higher the lethality or risk.

"Are you thinking of suicide?" Adolescents who have been preoccupied with suicidal thoughts may experience a sense of relief to know there is someone who is able to discuss suicide in a straightforward manner. Using the word "suicide" will convey that the helping professional is listening and is willing to be involved; using the word "suicide" will not put the idea of suicide in the mind of a nonsuicidal adolescent.

"How long have you been thinking about suicide?" Adolescents who have been preoccupied with suicide for a period of several weeks are more at risk than those who have only fleeting thoughts. One way to explore several components of this question is to remember the acronym "FID." When asking about suicidal thoughts, ask about *frequency*, or

how often they occur, *intensity*, or how dysfunctional the preoccupation is making the adolescent ("Can you go on with your daily routine as usual?"), and *duration*, or how long the periods of preoccupation last. Obviously, an adolescent who reports frequent periods of preoccupation so intense that it is difficult or impossible to go to school, to work, or to see friends, and for increasingly longer periods of time so that periods of preoccupation and dysfunction are merging, is more at risk than an adolescent who describes a different set of circumstances.

"Do you have a suicide plan?" When an adolescent is able to specify the method, the time, the place, and who will or will not be nearby, the risk is higher. (If the use of a gun, knife, medication, or other means is described, ask if that item is in a pocket or purse and request that the item be left with you. Never, however, enter into a struggle with an adolescent to remove a firearm. Call the police or local suicide or crisis center.) Most adolescents will cooperate with you by telling you about the plan and allowing you to separate them from the means. Remember, most suicidal adolescents are other-directed; such a trait should be taken advantage of during a crisis management situation. Later, when the crisis has subsided and counseling is initiated, the adolescent's internal locus of control can be strengthened.

"Do you know someone who has committed suicide?" If the answer is "yes," the adolescent may be at higher risk especially if this incident occurred within the family or a close network of friends. Such an adolescent may have come to believe that suicide is a legitimate problem-solving option.

"How much do you want to live?" An adolescent who can provide only a few reasons for wishing to continue with life is at higher risk than an adolescent who can enumerate a number of reasons for continuing to live.

"How much do you want to die?" The response to this question provides the opposite view of the one above. An adolescent who gives a variety of reasons for wishing to die is more at risk than an adolescent who cannot provide justification for ending life. It may be unnecessary to ask this question if the previous question provided adequate data.

"What do you think death is like?" This question can be an excellent tool of assessment. Adolescents who do not seem to realize that death is permanent, that there is not reversal possible, and that they cannot physically return are at higher risk for an actual attempt. Also, adolescents who have the idea that death will be "romantic," "nurturing," or "the solution to current problems" are at high risk.

"Have you attempted suicide in the past?" If the answer to this question is "yes," then the adolescent is more at risk. Another attempt may occur that could be successful because a previous attempter has

the memory of prior efforts and the fact that he or she conceptualized and carried through with a suicide plan. An additional attempt may correct deficits in the original plan and result in death.

"How long ago was this previous attempt?" is a question that should be asked of any adolescent who answers "yes" to the previous question. The more recent the previous attempt, the more at risk the adolescent is and the more critical is the crisis management process.

"Have you been feeling depressed?" Because a high percentage of adolescents who attempt or complete suicide are depressed, this is an important question. Using the acronym FID to remember to ask about frequency, intensity, and duration is also helpful in the context of exploring an adolescent's response to this question. As previously discussed, a determination needs to be made relative to the existence of clinical depression if such a condition is suspected. Adolescents who report frequent, intense, and lengthy periods of depression resulting in dysfunctional episodes that are becoming more frequent or are continuously experienced are at high risk.

"Is there anyone to stop you?" This is an extremely important question. If an adolescent has a difficult time identifying a friend, family member, or significant adult who is worth living for, the probability of a suicide attempt is high. Whoever the adolescent can identify should be specifically named; addresses, phone numbers, and the relationship to the adolescent should also be obtained. (If the adolescent cannot remember phone numbers and addresses, look up the information, together, in a phone book.) In the event it is decided that a suicide watch should be initiated, the people in the adolescent's network can be contacted and asked to participate.

"On a scale of 1 to 10, with 1 being low and 10 being high, what is the number that depicts the probability that you will attempt suicide?" The higher the number, the higher the lethality.

"Do you use alcohol or other drugs?" If the answer to this question is "yes," the lethality is higher because use of a substance further distorts cognition and weakens impulse control. An affirmative response should also be followed by an exploration of the degree of drug involvement and identification of specific drugs.

"Have you experienced significant losses during the past year or earlier losses you've never discussed?" Adolescents who have lost friends because of moving, vitality because of illness, their family of origin because of a divorce, and so forth are vulnerable to stress and confusion and are usually at higher risk for attempting or completing suicide if they have been preoccupied with such thoughts.

"Have you been concerned, in any way, with your sexuality?" This may be a difficult question to explore, even briefly, during a peaking

suicidal crisis. Generally, adolescents who are, or think they may be, gay or lesbian are at higher risk for suicide. It is difficult for adolescents to deal with the issue of sexual preference because of fear about being ridiculed or rejected. They may have experienced related guilt and stress for a number of years, never daring to discuss their feelings with anyone.

"When you think about yourself and the future, what do you visualize?" A high-risk adolescent will probably have difficulty visualizing a future scenario and will describe feeling too hopeless and depressed to even imagine a future life.

As noted at the beginning of this discussion, it is not necessary to ask all of these questions if the answers are shared during the course of the discussion. It should also be noted that the interviewing team must make judgments about the truthfulness of a specific response by considering the response in the total context of the interview.

10. Make crisis management decisions. If, as a result of an assessment made by at least two professionals, the adolescent is at risk for suicide, a number of crisis management interventions can be considered. They may be used singly or in combination; the actual combination will depend on the lethality determination, resources and people available, and professional judgment. It is the responsibility of the professionals involved, however, to develop a crisis management plan to be followed until the crisis subsides and long-term counseling or therapy can be initiated.

Notify parents. Parents of minors must be notified and asked for assistance when an adolescent is determined to be at risk for a suicide attempt. Often, adolescents may attempt to elicit a promise of confidentiality from a school or mental health counselor who learns about suicidal intent. Such confidentiality is not possible; the welfare of the adolescent is the most important consideration, and parents should be contacted as soon as possible.

Sometimes parents do not believe that their child is suicidal and refuse to leave home or work and meet with their son or daughter and members of the assessment team. At times parents may be adamant in their demands that the school or mental health professional withdraw their involvement. Although such attitudes are not conducive to the management of a suicidal crisis, they are understandable because parents may respond to such information with denial or anger to mask true emotions and cope with apprehensions that perhaps their child's situation reflects their personal inadequacies as people and parents. Because an adolescent at risk for a suicide attempt cannot be left unmonitored, this provides a dilemma for a school or a mental health agency. Because conforming to the wishes of noncooperative parents places the adolescent at even greater risk, steps must be taken despite parental protests.

Although some professionals worry about liability issues in such circumstances, liability is higher if such an adolescent is allowed to leave unmonitored and with no provision for follow-up assistance. Schools and mental health centers should confer with legal counsel to understand liability issues and to make sure that the best practices are followed in such circumstances.

Consider hospitalization. Hospitalization can be the option of choice during a suicidal crisis (even if the parents are cooperating) when the risk is high. An adolescent who has not been sleeping or eating, for example, may be totally exhausted or highly agitated. The care and safety that can be offered in a psychiatric unit of a hospital is often needed until the adolescent can experience a lowered level of stress, obtain food and rest, and realize that others consider the circumstances painful and worthy of attention. In many hospital settings, multidisciplinary teams (physicians, psychiatrists, counselors, social workers, nurses, nurse practitioners, teachers) work to individualize a treatment plan and provide for outpatient help as soon as the need for assistance on an inpatient basis subsides.

Write contracts. At times, professionals may decide that developing a contract with the adolescent may be enough to support the adolescent through a period of crisis and into a more positive frame of mind after which the adolescent would be more receptive to long-term counseling or therapy. Such a contract should be written out and signed and dated by the adolescent and the counselor. The contract can also be witnessed and signed by other professionals, friends, or family members.

Contracts should require the adolescent to:

1. Agree not to attempt suicide;
2. Obtain enough food and sleep;
3. Discard items that could be used in a suicide attempt (guns, weapons, medications, etc.);
4. Specify the time span of the contract;
5. Call a counselor, crisis center, etc., if there is a temptation to break the contract or attempt suicide;
6. Write down the phone numbers of people to contact if the feeling of crisis escalates; and
7. Specify ways time will be structured (walks, talks, movies, etc.).

Organize suicide watches. If hospital psychiatric services on an inpatient basis are not available in a given community and those doing the assessment believe the suicide risk is high, a suicide watch should be organized by contacting the individuals that the adolescent has identified in response to the question, "Is there anyone to stop you?" After receiving instruction and orientation from the professional, family members and friends should take turns staying with the adolescent until the crisis has subsided and long-term counseling or therapy has begun. In the opinion of the authors, it is never a good idea to depend on a family member alone to carry out a suicide watch; it is usually too difficult for family members to retain perspective. Friends should be contacted and included in a suicide watch even though confidentiality, as discussed earlier, cannot be maintained.

Postvention

Systemic. When an adolescent has attempted or completed a suicide, it is imperative, particularly in a school setting, to be aware of the impact of such an event on the "system." Usually, within just a few hours, the fact that an adolescent has attempted or completed suicide is chronicled through the peer group. This could present a problem to the faculty and staff in a given school building because not answering questions students raise can engender the sharing of misinformation or "rumors" and encourage open discussion that could embarrass an attempter upon his or her return.

The following guidelines should prove helpful.

1. The principal of the building in which a student has attempted or completed suicide (even though such an incident is most likely to occur off campus) should organize a telephone network to notify all faculty and staff that a mandatory meeting will take place prior to school the next morning. The principal should share information and answer questions about what happened during such a meeting.
2. Faculty and staff should be instructed to answer student questions that arise spontaneously but should be told not to initiate a discussion of suicide in general.
3. Faculty and staff should be told to excuse students from class if they are upset and need to spend time in the office of the building counselor or another member of a core or crisis team.
4. Parents who are upset by the suicidal incident should be directed to a designated individual to have questions answered. Parents should also be provided with options for counseling whether this counseling is provided by school personnel or referred to members of the mental health community.
5. At times, newspaper and television journalists contact the school for information about both the attempt or the completion and the school's response to the "aftermath." Again, it is important to direct all such inquiries to a designated individual to avoid

the problems created by inconsistency or sharing inaccurate information.

6. If a suicidal attempt occurs prior to the initiation of prevention and crisis management efforts in a given building, it is not a good idea to immediately initiate classroom mental health education even if faculty, staff, and core teams have been prepared and a written policy has been developed. Allow sufficient time to pass to prevent embarrassment to the returning student and his or her family.
7. Be alert to delayed or enhanced grief responses on the part of students prior to the anniversary of a suicide completion. Often students will need an opportunity to participate in a support group with peers or individual counseling prior to and, perhaps, beyond the anniversary date.

Individual and family. As many as 6 to 10 individuals (peers, family members, school faculty and staff, neighbors) may be profoundly affected by a suicide attempt or completion for 1 to 2 years afterwards (Capuzzi, 1988). Adolescents, family, or neighbors may be confused or assume guilt and responsibility for what has occurred and be in great need of assistance. Practitioners need to be aware of the need to provide counseling after a suicidal incident so that others don't become suicidal of dysfunctional in other ways.

One of the biggest mistakes adults make after an adolescent has attempted suicide is to fail to provide for long-term counseling for such an adolescent after a suicidal crisis has subsided. Because the "profile" of a suicidal adolescent is one that has developed over time, it is extremely critical to provide opportunities for "healing" and for overcoming life coping skill deficits that may have been developing over a period of years.

Concluding Remarks

The authors believe that individuals who are interested in working with suicidal youth must obtain more extensive information than that provided in this chapter. In addition, such individuals should obtain supervision from professionals qualified to provide such supervision after observing actual assessment interview and counseling/therapy sessions. Generally, neither assessment, preventive, or postvention sessions should be attempted by anyone who has graduated from a graduate program with *less than* a 2-year coursework and practicum/internship requirement. (In the case of counselors, such a graduate program should follow the standard set by the Council for the Accreditation of Counseling and Related Educational Programs.) In addition, membership in the American Association of Suicidology, participation in workshops and conferences focused on the topic of adolescent suicide, and consistent reading of the *Journal of Suicide and Life Threatening Behavior* and other books and journals are imperative.

Readers should also be cautioned not to use the material in this chapter as the sole basis for mental health education on the topic of adolescent suicide prevention or faculty/staff development in schools. This chapter provides an overview and an excellent starting point for professionals. Those without expertise on the topic or graduate preparation as a counselor, social worker, psychologist, or psychiatric nurse will not be able to answer questions of clients, families, and other professionals on the basis of reading a single chapter on this topic. Finally, anyone reading this chapter should be cautioned against initiating an adolescent suicide prevention, crisis management, and postvention program without writing a description of the various components so it can be checked by other professionals (including attorneys) and followed by all those involved in such an initiative.

An adolescent who becomes suicidal is communicating the fact that he or she is experiencing difficulty with tasks such as problem solving, managing stress, or expressing feelings. It is important for us to respond in constructive, safe, informed ways because the future of our communities (whether local, national, or international) is dependent upon individuals who are positive, functional, and able to cope with the complex demands of life. As research and clinical experience provide additional and more sophisticated information about adolescent suicide, it will be necessary to incorporate this information into prevention, crisis management, and postvention efforts. To abdicate our responsibility to do so would communicate a lack of interest in the youth of the 1990s and a lack of concern about the future of society.

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Chapter 12

TOUGH ENOUGH: GANG MEMBERSHIP

Alcena E. Boozer

This chapter examines the youth gang phenomenon. Setting the modern youth gang within the context of history and literature, the discussion includes a consideration of ethnicity as a factor in the organizational structure of gangs. Profiles of youth especially at risk for gang involvement are presented including a case study that illustrates common manifestations of risk factor patterns.

From the information base about gang organization, ethnic composition, and profiles and risk factors, the focus shifts to a presentation of strategies that have been found to be effective by schools that have experienced youth gang violence on their campuses. The chapter concludes with a description of a model for building community coalitions that has developed in Portland, Oregon, and a call for a restructuring of our educational institutions in order to eliminate conditions that contribute to the emergence and growth of youth gangs.

The Gang Phenomenon

Children Killing Children

Citizens of communities in urban areas have difficulty processing such devastating information. Gang involvement—a term that seemed relatively harmless is suddenly a term that produces responses of fear, anxiety, anger, rage and frustration—but mostly fear—fear of violence and fear of intimidation. Gang organization, presence, and activity are not new concepts. A cursory survey of the historical record and literary works testifies to the existence of groups who would meet the criteria established by Jackson and McBride (1987): "A gang is a group of people that form an allegiance for a common purpose, and engage in unlawful or criminal activity" (p. 20). The Legend of Robin Hood was about a gang. Not unlike some gangs operating today, Robin Hood's gang was believed to be helpful by some people in the communities in which it operated. Often modern street gangs first present themselves as "protectors" of the community. Yet Robin Hood's "Merry Men" carried weapons and their behavior, even though they robbed from the rich to give to the poor, was illegal under existing criminal codes of the era.

In 19th-century America, particularly in the West, a number of gangs operated. One of the best known, the Jesse James gang, terrorized a 16-state area. Gang activity, then as now, demanded a response from governmental officials. The governor of Missouri offered a reward for their arrest. In the 20th century groups were also organized to commit illegal and violent acts during the 1920s and 1930s. The best known gangs were active in Chicago and New York. The same violent illegal behaviors of robbery, violent assault, and murder characterized the 20th-century version of the gangster. Neighborhoods were sometimes severely affected as gangs battled each other for territorial control and routinely robbed, beat, or killed people as they sought to instill fear in a community.

By the 1940s the gang activity in the Western part of the United States was most clearly manifested in Southern California in Hispanic communities. Jackson and McBride (1987) described the early California gangs as encompassing street gangs, car clubs, and prison gangs. Although there were known Asian, Black, and Caucasian gangs operating in California from the 1920s on, the Hispanic gangs attracted the most interest of researchers because of the similarity of their internal structure.

> The structure of Hispanic street gangs is similar throughout the Western states. Codes of conduct have been established from which traditions have evolved over generations. These traditions are not written, but are handed down orally from generation to generation and are referred to as 'Moridas.' (p. 31)

One of the most frustrating characteristics of the modern youth gang that has evolved along the West Coast is the undefined nature of its structure. There seem to be no elective offices. One California gang investigator described it to a group of educators and law enforcement officers at a street gang training session meeting in Anaheim in 1987: "The leader is whoever is acting out most violently at a given time" (Boozer, 1987). There is little real internal control over the behavior of individual members and it is difficult to predict their behavior. Observations of gang activity will lead even the novice investigator to become concerned over the relative youth of gang members, given the levels of weapon use and violence. It is common to see 14–16-year-olds who identify themselves as "O.G." (original gangsters) and students as young as 12–13 carrying guns. Personnel from school districts in Southern California have cited the need to begin school-based programs geared toward prevention of youth gang involvement as early as the elementary grades. The city of Pomona presents a program on gang membership in its elementary schools and has added a unit entitled, "The Gang Membership Is Hazardous to Your Life Intermediate School Follow-Up" targeted for seventh graders. Such programmatic responses illustrate the level of community concern about a problem that is threatening the survival of affected neighborhoods and in some extreme cases, cities (Pomona Public Schools, 1987).

Visitors to the Los Angeles city and county area are struck by the pervasiveness of gang behavior. Everywhere, graffiti, the vehicle for mass communication among rival gangs, within gang subsets, and to those who are graffiti-literate in the outside world, serves notice that there is an ever-present threat level. The Los Angeles area recorded more than 350 gang-related deaths during 1987. Law enforcement officers have stated that many whose lives were lost were innocent bystanders, victims of a violent and unpredictable mentality that places loyalty to the gang above any other value. The threat to the greater community is perhaps more clearly delineated when one considers the extent of youth gang activity. It has been estimated that more than 70,000 individuals belong to the more than 300 gangs identified by law enforcement agencies as operating in Southern California (Boozer, 1987).

As Southern California law enforcement agencies responded to escalating levels of violence with more stringent arrest and detention policies and practices, another factor, the drug connection, contributed to the exodus of some of the Black gangs from the area. During the mid 1980s, people identified as members of the Crips and Bloods (Pirus) were observed in the Oakland, California, area and in the Pacific Northwest, most notably in Portland, Oregon, and Seattle, Washington. According to police department reports, the individuals believed to be gang members were arrested for trafficking in drugs, weapons possession and use, and assault and harassment. In the spring of 1987, it was estimated that 50 active gang members were operating in Portland, Oregon (Portland, OR, North/Northeast Youth Gang Task Force, 1987). Initial reports by the news media focused on the two major Black gangs, leading to a perception in some parts of the community that the "gang problem" was a Black problem. Members of the North/Northeast Youth Gang Task Force, who developed community gang awareness presentations, quickly recognized the need to provide information on the significance of ethnicity as a factor in youth gang organizational structures.

Ethnicity as a Factor in Youth Gang Organizational Structures

The Youth gangs that have emerged in cities along the West Coast of the United States reflect the ethnic pattern observed in Southern California.

> Youth gangs in California are usually organized along ethnic lines and are comprised of Asian, Black, Hispanic (Mexican-American or Chicano), and White groups. Although they tend to organize themselves according to ethnicity, the gangs (who constitute a very small segment of the population) are not representative of the ethnic community of which they are a part. (Suarez, 1987, p. 5)

There were 568 known gangs recorded in the 1987 California Gang Investigators' report. Ethnic distribution for the 568 gangs indicates that Hispanics, at 303, and Blacks, at 202, are the groups most heavily represented. Asian gang activity primarily encompasses the Southeast Asian refugee community and represents a small, but rapidly increasing percentage of the total number of gangs. White gangs, at 13, reflect a small percentage of the total (Pottier, 1982). The remaining number includes Samoans, Philippines, and Tongans. If one accepts the premise that young people join gangs to meet needs normally fulfilled through traditional institutions such as the home, church, and school and that, as a result of unequal access to economic opportunities and educational institutions, ethnic minorities have few opportunities to experience success, the overrepresentation of Hispanic and Black young adults in youth gang activity is not an unexpected phenomenon. In assessing the ethnic distribution of youth gang activity in a community, practitioners need to develop an awareness of economic and social issues that must be addressed in order to effectively discourage youth from joining gangs. Although unequal economic opportunity may in part account for the overrepresentation of ethnic minorities in youth gangs, it is important to recognize that gang activity is *not* limited to low-income youth. White gangs often include members from all economic levels (School Safety & Security Management, 1988).

Having established the fact that there is a measurable ethnic distribution of youth gangs that has recently been most intensively investigated in California, it can be now suggested that wherever significant gang activity has been reported, it will be related to the ethnic composition of the community. A comparison of Los Angeles, California, and the Pacific Northwest illustrates how ethnicity is reflected in gang activity. In Los Angeles, where Hispanics represent the largest minority group, the most detailed analyses are those dealing with Hispanic gangs. Conversely in the larger cities of the Pacific Northwest such as Portland, Oregon, and Seattle, Washington, where the Hispanic communities are relatively small, and Blacks make up the largest ethnic minority population, Black gangs receive the most attention from social science investigators and journalists. Concurrent with Black gangs, Asian gangs also are perceived as a major problem in communities where the Southeast Asian refugee community has rapidly increased and is concentrated in specific geographic areas. It has been the experience of cities recently encountering major youth gang problems that any organized response must be undertaken by groups and individuals who possess a thorough knowledge of the cultural experience of those who compose a given gang's membership.

All ethnic gangs mentioned in this discussion meet the criteria established by the California Gang Investigators' (Pottier, 1982) definition of a gang. Differences that can be identified, however, distinguish a gang as unique as a result of ethnicity. Graffiti is a relevant factor of the ethnic gangs cited in this discussion. It serves as a major vehicle for communication within and between gangs in an ethnically distinctive manner.

Graffiti

Hispanic Graffiti

In terms of the modern street gangs (after 1940), the most highly developed graffiti is that used by Hispanic groups. It is highly stylized and structured, requiring much effort to perfect to a level deemed worthy of the work now adorning walls of public and private buildings and structures throughout urban America. Jackson and McBride (1987) identified basic elements of Hispanic gang writing:

> . . . *logo*, a descriptive emblem used to identify the gang. May include Roman numerals, initials, name or symbol; *placa*, name or nicknames of person who puts up the graffiti; assertions of the gang's strength or power; closing example p/v, for por vida, a reference to the length of time the gang will be in control of the turf: forever. (pp. 63–64)

Black Graffiti

To the casual observer, Black gang graffiti, which started appearing in the 1970s, may not seem to differ greatly from Hispanic work. Closer examination reveals differences in style; it has less flair and attention to detail, and the content emphasizes individual prowess rather than gang strength (Jackson & McBride, 1987). Black gangs frequently include statements of intent to harm rival gangs or gang members. Numbers 1,2,3 are often replaced with the terms *ace*, *deuce*, and *trey* (i.e., 52nd street becomes *five deuce*; 83rd becomes *eight, tray or trey*) (Suarez, 1987). Black gangs tend to use graffiti displays to announce their presence in a community and to list the roster of gang members, including real names and street *monikers*. It is therefore a source of intelligence regarding a gang's strength and intentions in a community or school. School administrators and police personnel have found graffiti literacy to be a helpful skill to develop.

Asian Graffiti

Asian graffiti resembles Hispanic more closely than Black in terms of stylization and attention to detail. Most frequently used to claim a territory, it contains little information other than the gang name. Once law enforcement agencies began tracking Asian graffiti in the Northwest, there was a decreased level of activity.

White Graffiti

In 1987 Jackson and McBride and Suarez viewed White graffiti as the work of two groups, the *Stoners* and *White Power Supremacist* groups. Content in White graffiti centers on White racist statements, satanic symbols, or demonic wording and alludes to heavy metal rock music groups. The satanic symbols, upside down crosses with numbers *666* on both ends, and the pentagram are frequently seen. Many words are spelled backwards, for example, "Snatas Srewollof," or Satan's Followers. Stoners select nicknames that connote a demonic nature or violent, antisocial acts (Jackson & McBride).

Distinctive styles of dress among gang members also reflect an ethnic gang style, but one that is not, however, related to a style that can be attributed to ethnic cultural tradition. Gang members may adopt certain items of apparel that are worn in designated colors or in specific ways. (It is suggested that individuals desiring to develop a working awareness of street gangs consult the references noted or contact one of the law enforcement agencies in the Los Angeles area, or Portland, Oregon, for more detailed information.) Members of the Black Crips gang wear items of blue clothing to designate their allegiance. Their arch rivals, the Bloods, display red clothing. The colors differ, but the items that symbolize gang affiliation are the same such as work bandannas, colored shoelaces, and the style of wearing them. The work bandannas are worn hanging out of the rear trouser pockets or tied around the head as a sweatband. Trousers are often worn loosely with the belt line near the mid to lower hip level; such a practice is referred to as "saggin."

In communities where Black gang activity is escalating, involved young people may demonstrate an almost fanatical loyalty to the gang's *color.* Often the presenting indicator of gang activity will be a fight because someone *disrespected* a rival gang's color.

White gangs adapt the types of outfits associated with motorcycle or biker gangs. Favored items include black leather jackets, chains, leather boots, jeans, or military type clothing. Items of clothing are adorned with satan's symbols or names of punk rock and heavy metal groups.

Often young people with no gang affiliation will begin to wear gang-like clothing in an effort to demonstrate readiness and willingness to join a group. School staff and community workers need to keep current vis-a-vis gang apparel. Often an adolescent's abrupt change in clothing style signals the intent to become a "wanna be."

Gang Violence

Ethnic orientation in youth gangs does not automatically result in interethnic gang rivalry and warfare. Most intergang violence is intraethnic. Hispanic gangs tend to fight other Hispanic gangs and Black gangs tend to do battle with other Black gangs. Although not unknown, it is not a common practice for members of one ethnic group to join a gang representing another minority group. Occasionally, a Hispanic may join a Black gang or vice versa. In the early days of the Stoner groups, there were occasional reports of Black members. The limited conflict that does occur on an interethnic basis tends to be between White supremacist groups and individual members of other groups. There is current concern that there will be violent confrontations between Southeast Asian gangs and Black gangs as they battle over control of the drug trade along the West Coast.

From the discussion above, ethnicity is seen to be a factor in youth gang organization in that gangs usually form out of existing friendship/acquaintance patterns in a given community. The frame of reference or world view of the gang members reflects their common heritage and self-perception as individuals who need one another to gain affirmation and acceptance and a feeling of self-worth. As they go through the process of becoming a gang, they build on their most easily identified and basic common traits that set them apart from the rest of the community. Sadly, far too often the factor that most clearly sets a group apart is ethnic identification. This is validated by finding a perverse pride of race in violent confrontation with the power structure in the community, which represents power and privilege that is inaccessible on any other basis.

Profiles of Youth Especially at Risk of Gang Involvement

The youngest gang member to come to this writer's attention was 8 years old when referred for youth gang outreach services. A brief sketch of his experience will help to develop a composite profile of children most severely at risk of becoming involved in a gang. Hezekiah (not a real name) was well known to the staff of the elementary school that he attended. They had known him as a 2-year-old toddler who wandered the streets alone. Older children often brought him into the school where he was fed and attempts were made to contact his mother. Referrals were made to local agencies. Hezekiah was taken from his mother's custody, and a grandparent was appointed as guardian. The grandmother was also guardian for four other older boys who were abandoned by their parents. Although the grandmother expressed the desire to help her five grandsons, at age 63, she no longer had the energy, will, or resources to administer discipline consistently. There were few attempts to do anything for Hezekiah beyond the most basic needs for food and shelter. As indicated above, he was seldom missed when he disappeared from home for hours at a time from the day he learned to toddle along the streets of the neighborhood.

The people on the streets, many of them gang members, became Hezekiah's "family." From them he learned to talk and to become physically aggressive. With gang members as role models, this miniature "O.G." (original gangster) mastered the vernacular and concomitant nonverbal behaviors. The staff at the early childhood education center that he attended referred him to social workers and child development specialists for violent aggressive behavior and inappropriate sexually oriented gestures in the classroom. The primary grades for Hezekiah were times of constant conflict with other children and the school staff. Frustrated by the seeming lack of programs to deal effectively with what was perceived as grossly inappropriate behavior, the principal resorted to out-of-school suspension. Hezekiah learned quickly that when he didn't want to be in school, he needed only to "act out" and the school would send him home—home to the streets where stories of his negative behavior became a source of entertainment to the members of his street family, the gang. This young man was well on his way toward becoming a neighborhood legend. His name appeared in the graffiti around the neighborhood. He organized other children who were poorly supervised into a minigang, whose members armed themselves with baseball bats and started to shake down the neighborhood children. At this point, the school staff contacted members of a newly formed Youth Gang Task Force, a consortium of youth-serving agencies, neighborhood activists, central program school administrators, and juvenile justice and law enforcement personnel. In the conferences and staffings that were scheduled, it was pointed out that in many ways Hezekiah was a classic example of the growth and nurturance of a gang member.

Hochhaus and Sousa (1988), in their study of young gang members ages 13–16, learned from gang members that "Companionship, protection, and excitement—combined with peer pressure—are the most frequent motivations for joining a gang" (p. 75). Hezekiah received little attention in the home of his grandmother. He was abandoned by his mother. The people of the streets, gang members or children who looked to gang members as role models, offered the companionship he needed and sought. This extended street family also conveyed to him a sense of protection. Anybody who "messed with the little dude" would answer to the local gang chieftain. Perhaps most important to Hezekiah, the gang was a source of excitement. As Hochhaus and Sousa (1988) indicated, excitement was a powerful motivation for the boy to join the gang. It served to fill a void in his life with actions that were fun and exciting.

The profile sketched above could serve as a dire predictor of a life as a gang member that would become more and more violent until, most likely before the age of 24, Hezekiah would be either incarcerated or killed. In this case, the subject was diverted from this path by the intervention of one committed individual in Hezekiah's life.

Helping interventions will be discussed in greater detail in sections that follow. At this point other factors that contribute to placing a young person at risk of becoming involved with gang activity will be presented. It will come as no surprise to practitioners in the field of education that factors that place one at risk of gang involvement differ little from those that place a student in any other at-risk category, be it dropping out of school or becoming a teen parent. A general statement that might be applied to help a school staff come to grips with the gang issue is: "busy, successful students do not join gangs." Students who join gangs do not feel competent as learners, are seldom affirmed by anyone of the school staff, and do not feel connected or bonded to the school.

To help identify young people most severely at risk, most recent publications include lists of behaviors, which, when seen in definitive patterns, are believed to be strong indicators of probable gang involvement. "Gangs in Schools," a booklet published by the National School Safety Center (NSSC, 1988) lists the following as warning signs:

- Rumors or reliable information that a youth has not been home for several nights;
- Evidence of increased substance abuse;
- Abrupt changes in behavior and personality;
- Newly acquired and unexplained "wealth" often showered on or shared with peers (anything from sharing bags of candy with younger children to a flurry of more extravagant spending by older youth);
- Requests to borrow money;
- "Hanging around," but being unable to discuss the problem;
- Evidence of mental or physical child abuse; and
- A dress code that applies to a few: i.e., wearing of a color, style, or item of clothing, a particular hair style, and symbols of identification. (p. 10)

Such behavior patterns are most likely to occur among: youth who are from a one-parent home, with the single parent being the mother; families whose income is at or below the poverty level; children who live in a gang-infested neighborhood; or children who have parents or older siblings who are known by law enforcement agencies for criminal racketeering.

Needs That Gangs Meet

In the profile of Hezekiah three needs were discussed and often cited by the participants themselves as needs met by gangs—companionship, protection, and excitement. Gangs also meet the need that all individuals have to be affirmed—as Jesse Jackson says, to be able to say "I am somebody!" Frequently the first to be recruited when a gang comes to town are those who feel that they are "nobodies" in the social milieu of the school community. Magnus Seng (1986), in an article in the *Journal of American Secondary Education*, presented a conceptual framework for gang development in suburban communities. The first stage Seng identified is labeled "A Company of Rejects, a loose collection of individuals each of whom is angry" (p. 10). The "loose collection" includes children who feel set apart for a variety of reasons and may include poor children, the ethnically different, or children considered fat, ugly, or dumb by their peers. "It is in the high school setting that these 'rejects' find each other. They tend to hang out together, to become a loose collection of individuals" (Seng, p. 12).

It is critically important for school staff to be aware of students who make up the "community of rejects." Although they can be found in all schools, their presence does not predestine the school for gang problems. The school community always has the opportunity to intervene with the community of rejects and coax them back into the greater community before they begin to perceive themselves as a gang. This is most easily and effectively accomplished if counselors and teachers accept roles as intervention specialists in the schools' efforts to divert students from youth gang activity. The writer, when working with school staffs on youth gang issues, frequently challenges teachers to think about the most difficult student they have in class, to review the pattern of inappropriate behaviors, and then to weigh them against the ways that they, individually, or the school, collectively, communicate with that student. In how many ways does the school affirm a member of the "company of rejects" is a question that must be pondered daily if we are successfully to convince the community of rejects that they are "somebodies" and that they can experience success in the school environment.

Continuing to think about the needs that gangs meet for children at risk will bring us face-to-face with a major dilemma. How can we compete with the attraction of lots of fast, easy money, which in the eyes of children drawn to gangs is equated with economic security? Gang members as role models are powerful symbols in poorer neighborhoods. They possess the "three Cs"—cars, clothes, and cash. They seem to have the ability to do as they please, intimidating the normal institutions that exercise social control—the schools, churches, and in some cases, law enforcement agencies. Successful programs to counter the economic attraction of gang activity need to include an employment/job training component. Those who staff such programs need to develop an awareness of and appreciation for the perceived economic and physical power of the gang in a given neighborhood. Effective strategies include enlisting the cooperation of former gang members. They can serve as key links between the gang and the community. They are in essence bicultural and have sufficient credibility to persuade and teach gang members, through appropriate language, signs, and symbols, to control their violent behavior (Spergel, 1986). Once violent behavior decreases, gang members are more open to consider alternative avenues toward economic security.

This discussion has touched upon several needs that gangs fill: security, affirmation, protection, companionship, excitement. Most of the needs cited relate to issues of self-esteem, a primary area of interest and concern to school counselors. In terms of needs of children and youth gangs, counselors are in a unique position to help the total school staff assess its ability to work with students in ways that enhance self-esteem. The author hopes that the information presented in this chapter will encourage counselors to initiate programs and activities to deal with those issues in a context that reflects sensitivity to cultural and ethnic factors related to the root causes that make gang behavior seem to be a reasonable response for the poor, the ethnically different, and the less able—all those who compose the company of rejects.

Coming to Grips With Fear, Intimidation, Confrontation, and Violence on the Campus

Schools in communities where even minimal indicators of gang activity are discernible must adopt a policy of assertive vigilance and preparedness. Once a violent act occurs on a campus, a well-designed response plan must be activated to contain the disruptive influence of both the gang and the level of community fear and security resulting from the perceived power of the gang. Essential components of effective response plans include the involvement of law enforcement officials and a detailed communications plan. The National School Safety Center (NSSC) (1988) stressed the need for the plan to "assume constant and consistent communications and designate responsibilities to specific staff members and administrators, in order to get the facts to the proper authorities, parents and general public" (p. 33). It is essential to avoid the sometimes well-intentioned effort to withhold information to "keep the situation under control," or "avoid creating hysteria." People want and need to know what happened and more importantly, they want to know what's being done about it. Specifically the NSSC recommends that schools:

> Have a media policy worked out in advance. Spell out who will be the media contact, and make it clear that no one else will speak officially for the school or school district. Simultaneously keep school employees and students informed. They are going to be unofficial representatives who are going to serve as key communicators in the community. In addition to the written media policy, school security departments need to:

1. *Acknowledge the problem immediately* and get help from local police and community groups.
2. *Educate security personnel.*
3. *Establish informed communication networks* with the kids.
4. *Institute a strict visitors/trespassers policy.*
5. *Control school access points.*
6. *Remove graffiti* as quickly as possible.
7. *Work closely with local police*, especially work to establish procedures whereby information may be shared.
8. *Consider the use of cameras* to take pictures of suspicious visitors or trespassers.
9. *Maintain a high profile*: consider using uniformed security personnel strategically in places to ensure maximum visibility.
10. *Form or access a community network.* (pp. 33–34)

To many educators, taking measures such as those listed above might seem to be the antithesis of what one expects to do in an educational environment. Gang behavior and its associated violence, however, constitute a threat to the educational community such as it has never known. Failure to deal realistically and firmly could result in tragic loss of young lives on our school campuses. The experience of school personnel who have been tested in the crucible of crisis indicates that it is imperative to have a crisis counseling team immediately available to work with students who have been affected by violence on a campus. The crisis team members should be experienced in working with adolescents and have training in the grief counseling process. They should be prepared to, in essence, "wander about the campus," making themselves available to young people who need to talk and need someone to listen. Crisis team counselors need to be equally available to staff members who may need assistance in working through their own feelings.

The Role of the School Counseling Staff in Coordinating School and Community Training Activities

A review of recent literature on youth gangs in schools leaves one with the impression that dealing with youth gangs has become the primary domain of security and disciplinary personnel. There is a strong emphasis on the need to tighten up disciplinary procedures and measures. Although it is not desirable to minimize the need for such containment policies, it is, in the writer's opinion, critical to involve the counseling staff in the planning and coordination of school and community training activities.

As indicated earlier in this chapter, young people join youth gangs to fill needs that are not being met for some marginal students either in the schools or the community. The counseling staff, if permitted the time to work with students individually or on a small group basis, is best suited by training and professional responsibility to engage the students in an intentional process that will enable them to explore their own needs, weigh consequences of gang affiliation, and explore alternative options for fulfilling their needs.

When training or gang awareness activities are scheduled in the community, emotions tend to peak. An approach based on a police, security-oriented rationale tends to polarize communities, particularly those with a history of police/minority group conflict and tension. The potential for new conflicts over how the community responds to gangs can be decreased by processing the information through a counseling-based frame of reference. Counselors should be on the planning team to design a school or district response plan related to youth gangs.

A unique role for the counseling department in the Portland, Oregon, school district's response to youth gangs was to develop and teach a "youth gang awareness" unit in grades 4 and 5. The unit was designed to provide a vehicle for the intervention work necessary to interrupt the cycle of "wanna be" behaviors before they become entrenched and escalate through the stages identified by Seng (1986) from a "gang in embryo" to hard core gangsters. The gang awareness activities dovetail with the self-esteem, drug awareness, and personal safety issues taught by the child development specialists assigned to each elementary (K–5) school. At the middle and high school levels a "violence prevention curriculum" developed in Boston, Massachusetts, is being adapted and will be introduced during the 1988–89 school year. This curriculum focuses on the dynamics of violent encounter, the identification of behaviors likely to trigger or evoke a violent response, and the learning and practicing of behaviors that can defuse such situations. Again, such discussions are natural turf for school counselors.

Educating the Community

When gangs move into a community, one of the first agencies looked to for help is the local school district. Many gang members and those perceived to be gang members are school-aged; an assumption is made that they are enrolled in school, therefore the school is the logical agency "to do something." On lists of things recommended for schools to do, one frequently notes a call to "form a community network or coalition." It will be helpful, for illustrative purposes, to present a case study of the Portland, Oregon, North/Northeast Youth Gangs-Youth Concerns Task Force (1987).

Portland's population of 404,293 contains over 174,000 households. Eighty-seven percent of the population is White, 7% Black, 3% Asian, and 1% Native American. Forty-four percent of the Black population resides in the north/northeast cluster of neighborhoods. The north/northeast neighborhoods have higher crime rates, lower family income rates, and more single-person households than other neighborhoods (City of Portland, OR, 1987). The schools in the north/northeast neighborhoods report more disciplinary suspensions, particularly for Black children. There are fewer economic opportunities available to young men aged 16–25. During the spring of 1987 the schools and neighborhood crime prevention offices began to receive telephone calls form anxious parents demanding to know why their children were afraid to wear certain colors of clothing to school. Puzzled staff members started to investigate the situation. Juvenile court counselors were among the first to verify the presence of known members of Los Angeles-based gangs in North Portland neighborhoods. There were 19 gang-related crimes reported in the city in a 6-week period in the spring of 1987 (Portland, OR, North/Northeast Youth Gang Task Force, 1987). Drive-by shootings were included in the gang-related crimes, causing much heated debate at a series of neighborhood meetings. Neighborhood activists and staff members in the police department of the school district and youth serving organizations, and reporters from local TV stations in the city organized as a youth gangs task force. Members of the task force solicited the support of upper-echelon administrators to send a representative group of 16 people to Anaheim, California, to attend a training conference sponsored by the California Gang Investigators Association entitled, "Street Gang Training for Police and Community Board Organizations" (Boozer, 1987).

Local media provided intensive coverage of the local task force's journey, and the members lost no time in taking advantage of the public attention. A proposal was written and funding was obtained to hire a gang task force coordinator and two neighborhood outreach workers, and install a gang hotline to assist in rumor control. As the task force program was being organized, the agencies represented on the task force initiated their own in-house "anti-gang" programs. At regular meetings agencies were apprised of one another's efforts, and in a number of instances there were joint ventures. Several public presentation teams were organized, and, at the request of civic organizations, churches, and public agencies, gang awareness training was offered to all who wished to become informed. At the time of this writing, the State Human Resources Department management, public utilities management, field personnel, bankers, a variety of professional associations, and school support personnel have completed a gang awareness training program entitled "Gangbusters 101."

The public education component of any community's effort to respond to the challenge of youth gangs is the most critical link. Without an informed community, there will not be the support and pressure on agencies to fund the kinds of intervention, prevention, and enforcement programs needed to save a city's youth from the hazards associated with youth gang membership. The Portland, OR, North/Northeast Youth Gang Task Force case has illustrated that process. As the first signs of youth gang activity were documented, contacts were made with other cities to learn what kinds of strategies had been tried to contain the growth and spread of gang activity. The message received from cities in Southern California was that they had waited much too long to act. Referring back to the Seng model, they had failed to deal with the "company of rejects" and as a result had had to try to deal with each successive level, concluding that at every step they were doing much too little much too late. The message deeply affected the members of the Portland task force. They returned home and started the public information campaign, dubbed by some of them as a Holy Crusade, to save our most precious resource—our children. Politicians in an election year discovered that it was best not to ignore this vocal group that had captured the public's attention and that was committed to using its growing influence "to help our friends and ignore those who ignore us."

Some problems contributing to the growth of street gangs were being debated in Oregon, a major one being a lack of jail space. As an editorial in *The Oregonian* stated, "Word is out on the streets of Portland, Los Angeles, Seattle and Sacramento: In Portland, the "living is easy" for cocaine and crack dealers. The territory's open and the money's big. Law enforcement is handcuffed by the absence of jail space" ("Pull Down Gangs," 1988).

Building Coalitions to Provide Positive Alternatives to Youth Gang Membership

Effective positive alternatives to youth gang membership need to include opportunities for children and young adults to become aware of youth gangs and weigh the consequences of youth gang membership in order to make wise personal decisions about how they will seek to fulfill their personal needs and to build self-esteem. Schools acting in isolation cannot meet those needs. Therefore it is incumbent upon the school staff to establish working relationships with other agencies and institutions in the community and engage in a problem-solving process to generate creative proposals to implement appropriate intervention programs. As indicated in the Portland case study, the first step in building the coalition involves a coming together of staff members who provide direct youth services. People such as juvenile parole counselors, youth service center and recreational center counselors, school counselors, attendance counselors, and neighborhood crime prevention specialists are in the best position to provide accurate information about the level of gang type behavior that may be present in a given neighborhood or community. It is at this level that descriptive documents can be prepared to sensitize mid-level managers and enlist their support for the creation of a community-based task force.

The concept of a community-based task force is a fundamental building block of a coalition to provide positive alternatives to youth gang membership. The targeted group, youth at risk for gang involvement, often have little confidence in the agencies charged to serve them. Such youths have experienced little if any success in school. Their experiences with law enforcement agencies have often not been positive. They have expressed little interest in participating in the activities sponsored by the traditional groups such as YMCA or YWCA, boys clubs, scouts or camp fire, and churches. To reach marginal youth, people involved will have to "speak the language" of the streets. People who speak the language of the streets are most likely to be identified at open forums designated to share information and listen to citizen complaints. At open community forums care should be taken to identify "fringe people." The fringe people operate in both traditional social settings and in the world of the gang members. The affirmation and increased self-esteem they are seeking might be obtained in the emerging community-based task force. They should be included in debriefing sessions following the community forums and invited to participate in the design and development of funding proposals. The inclusion of such individuals broadens the base of the coalition and helps to ensure that the perspective of those most at risk of gang involvement will not be lost in the bureaucratic organizational process that is sure to emerge if public funding is to be obtained.

One of the potential pitfalls of the coalition-building activities is the tendency of neighborhood activists and school agency representatives to polarize around issues of improvement. The activists sometimes feel that gangs emerge as a result of the failure of the traditional youth service/educational agencies to meet the needs of poor and minority children. The agency representatives and educators sometimes grow impatient with the process or become defensive about perceived criticisms of their efforts. At this stage, those school counselors and neighborhood youth counselors who have established a reputation for being able to create and maintain positive rapport with the activist community should be used as facilitators of a series of workshops and retreats. The new coalition can move beyond "hidden agendas" and create a working task force. Such a task force must be capable of motivating and energizing sustained community organization and school-based programmatic efforts. The resultant combined resources will be able to set in place a continuum of activities to identify the students at risk at an early age and to engage them in the educational, social, and economic experiences that will discourage the pursuit of violent, illegal gang activity.

Once the funding proposals have been completed, the individual representatives of the cooperating agencies and community organizations and neighborhood activists need to return to their respective communities to enlist the aid of their upper-level management groups and boards of directors. This is another critical point in the process. Some cooperating agencies will be more responsive than others. The strategic response found to be most productive has been to work with the agencies willing to provide support. The other, less enthusiastic agencies tend to get on board once public attention is focused on the activities of the coalition.

As the public agencies respond, coalition members need to move into the private corporate sector, offering to provide informational workshops, seminars, or luncheon speakers. The private sector, correctly perceiving that increased gang activity has a negative economic impact, often provides significant support for coalition efforts.

An important community to include in the emerging coalition is the religious establishment. The churches, synagogues, and mosques of a community are the natural institutions that provide training and support to young people who are struggling with ethical choices and moral issues. They should be included in the organizational efforts and encouraged to offer activities to help families and children to find productive ways to use leisure time constructively. In some communities, religious organizations have sponsored after-school homework centers or offered space for Saturday school programs. One church in Portland sponsored a program in which children who were out of school on suspension could be supervised and helped with their assignments. Another group is sponsoring a "released-time" religious education program that also offers after-school and weekend recreational activities. Both the school staff and the volunteers from the religious community are careful to maintain the traditional separation between church and state. While maintaining the required separation, they have managed to identify areas of mutual concern and areas where they can complement one another's efforts to enhance the opportunities for children to experience success and affirmation in their lives.

The opportunities for creative cooperation available to a community coalition are limited only by the imagination and ingenuity of its members. The problems associated with youth gangs are frightening and, in a sense, overwhelming. Yet as communities begin seriously to examine what is happening in terms of the quality of life available to the coming generation, they will discover that the greatest gains are sometimes made under conditions of greatest stress. The school, as the institution primarily responsible for the education of the next generation, is faced with situations creating a stress capable of crumbling the whole structure. School staff members are finding the cracks and beginning the repair work to support the existing structure until the time that our new one, which we have been building all along, is complete.

The new structure will have no need for security systems, fences, and armed law enforcement officers. Inside the new structure young people will be nurtured and affirmed in ways that will make it almost impossible to understand that part of the social studies curriculum that talked about the youth gangs of the 1980s and "at-risk children." It is hoped that the historical record for this turbulent time will indicate that the school initiated, encouraged, and cooperated in a community-based program that resulted in the decrease in acting-out behaviors and the disappearance of the violent youth gangs at the turn of the 21st century.

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Chapter 13

"WHY SAY NO?": SUBSTANCE ABUSE AMONG TEENAGERS

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One of the most challenging problems facing society today is the use and abuse of chemical substances by teenagers. In addition to cigarettes, teenagers use many illicit chemical substances such as alcohol, marijuana, cocaine, and inhalants. Abuse of these substances often results in harm not only to the individual teen but also to society. For instance, research has shown that the use of alcohol is associated with 60% of all murders, 40% of all assaults, and 33% of all rapes and child molesting (Department of Health and Human Services, 1984; Tinklenberg, 1973). Our criminal justice system as well as our health care system are experiencing the exploding impact of substance abuse. Millions of dollars are spent yearly in hospitals and special treatment programs to treat crises. In October 1986, the Drug-Free Schools and Communities Act was passed, and the Department of Education received $200 million for drug abuse education in the schools (Business Research Publications, 1987).

The questions we all face are: Who are the adolescents most at risk for substance abuse, and what steps can be taken to prevent or to stop teen substance abuse? Neither of these questions is easily answered. As an initial step in understanding the magnitude of and the issues involved in substance abuse, it is imperative to examine adolescent substance abuse from a variety of perspectives—psychosocial, historical/legal, and psychophysiological. The role of schools, parents, and treatment programs must be addressed as well.

Prior to beginning a discussion of these issues, I would like to emphasize two things. The first is that drugs, in and of themselves, are not good or bad, and second, drug use is not necessarily the same as drug abuse. What influences our value judgments about the positive or negative effects of certain chemical substances is who takes them, for what purpose, when and where they are taken, and how much and how frequently they are taken. For example, a successful business person having a nightly cocktail before dinner to unwind from a hectic, demanding job is not an unusual scenario in American society. In contrast, we would be very concerned about a 14-year-old who has a drink or two because his or her days are stressful. Whereas one situation is viewed as relatively benign, the other can be viewed as "bad" and the user at risk for abuse.

In addition to alcohol and cigarettes, almost all adolescents have been exposed to illicit drugs, and a high percentage have experimented with them. According to Borton (1983), half of all seventh graders have been pressured to try marijuana. By 12th grade, about 57% have given in to this pressure (Johnston, O'Malley, & Bachman, 1984) and 5.5% use it daily. These statistics do not take into consideration those who have dropped out of high school and are even more likely to have used drugs.

Use rates among seniors for other substances "used at some time in their life" include: alcohol (93%); stimulants (27%); cocaine (16%); hallucinogens (15%); sedatives or barbiturates (14%); inhalants (14%); tranquilizers (13%); opiates (non-heroin) (10%); LSD (9%); and amyl and butyl nitrates (8%) (Beschner, 1986, p. 2). Despite these statistics on the types of drugs used, we still understand very little about the adolescent substance user.

Psychosocial Perspective

Jalali, Jalali, Crocette, and Turner (1981) classified adolescent users as experimenters, compulsive users, or floaters. Floaters alternate between experimenting with drugs and being compulsive users. Although experimenters may try drugs out of boredom or curiosity, in the hope of having fun, or in response to peer pressure, they typically use drugs in small amounts and infrequently. Usually they try only alcohol or marijuana and are aware of the difference between having fun and getting into danger. Typically these teenagers do not develop serious drug problems.

A few unlucky teens, however, will become compulsive users, and their lives and health will be at risk due to their drug abuse. For these youth, drugs are an escape. Generally, they have poor relationships with their parents, with their conventional peers, and with school personnel, and have strong relationships with drug-using peers (Dembo, Blount, Schmeider, & Burgos, 1985). These youth often experience self-derogation, depression, and alienation, which are acted out as rebelliousness, aggressiveness, independence, and risk-taking behaviors aimed at sensation seeking (Dembo et al.). More and more of their time and energy is devoted to getting high, and they become connoisseurs of street drugs (Beschner, 1986). Although the data are not exact, it is estimated that between 4% and 5% of teenagers between the ages of 15 and 19 use illicit drugs regularly. This represents about one million teenagers—a staggering number.

According to the literature review by Dembo et al. (1985) on the etiology of drug use, of these one million, the user who is White is most likely to be using alcohol or marijuana. Ethnic minority youth (Black, Native American, and Hispanic) are more likely to use alcohol and drugs other than marijuana. Although no gender and socioeconomic differences seem to exist, use seems to escalate until around age 19, when a decline occurs. The earlier use starts, the greater the potential for deviant behavior, self-derogation, and feelings of rejection by family and peers. In response to feeling rejected, adolescents seek a social climate that accepts and supports drug use and tolerates or endorses crime and other socially deviant behaviors.

This is the extreme scenario, but many youth are rapidly moving toward the compulsive user status. Still, many have been able to stay "clean" or have merely experimented with a substance and have not become regular users. Research is just beginning to address the psychosocial differences between these groups and why some become abusers and others do not.

Historical and Legal Perspective

The use of drugs has not always been considered problematic. Indeed, a review of the political and legislative history of drugs reveals that substance abuse among adolescents is a relatively recent problem. In the early 1800s, the only law America had that regulated drug sales and use was the excise tax on whiskey Congress passed in 1791. Although a regulatory tax was placed on imported opium in 1842, by 1875 opium dens were flourishing and there were reports that the young women and men from respectable families were being ruined. In 1875 San Francisco and in 1882 New York passed laws prohibiting the smoking of opium. The federal government passed an act in 1890 stipulating that only American citizens could import opium. Although this act did not make opium smoking illegal, it did protect the national economy. This tendency seems to have influenced drug regulation policy ever since.

By 1914 it was estimated that 1 in every 400 Americans was addicted to opium or its derivatives. Leading the fight against narcotics use, Dr. Alexander Wright drafted the Harrison Act, which outlawed heroin and put medical controls on other opiates and cocaine. In 1919 the Supreme Court upheld the Narcotics Division decree that providing any narcotic to an addict was not a legitimate medical purpose, and physicians who did so were to be arrested. Between 1919 and 1929, 75,000 narcotics arrests were made and 25,000 among these were physicians and druggists (Ray & Ksir, 1987). To protect themselves, those in the medical professions began to refuse to treat addicts.

Although several local governments opened special clinics to supply legal narcotics, they often were staffed with untrained society-lady volunteers who were unfamiliar with narcotics and the culture of the poorer communities where the clinics were placed. As a result, young men who were not addicts often entered the clinics to obtain a legal dosage of the narcotic and then proceeded to sell their dosage to addicts waiting to get into the clinic. This environment fostered the beginning of the drug black market. Because addicts could no longer get their drugs legally, this illicit drug trade began to flourish, and drugs were sold for 50 times the legal medical price.

During this period, Richard Pearson Hobson, who had gained a national reputation as "Prohibitionist Hobson," warned of demonic drug pushers and created the myth of the dope fiend. His speeches and writings on teenage addiction lead to the passage of the Marijuana Tax Act in 1937, which brought marijuana under the same legal control as narcotics, with the same criminal penalties for sale or possession. Harry Anslinger, who had been appointed director of the Federal Bureau of Narcotics in 1932, claimed that marijuana was the "assassin of youth" and that it caused insanity, murder, rape, and impotence (Mandel & Feldman, 1986). One of his most memorable images was of "rosy-cheeked, innocent girls, lured to inner-city neighborhoods by a misguided sense of excitement, waking up after smoking marijuana for the first time with the realization that they had been debauched by lower-class males"(Mandel & Feldman, p. 23).

Heroin gained popularity among inner-city White youths in street gangs, and the young addict of the 1950s looked and behaved like the dope fiend earlier described by Hobson. To counteract the growth of heroin use, the Narcotics Drug Control Act of 1956 mandated tough penalties for every offense except first-offense possession and sanctioned the death penalty for anyone caught selling heroin to a minor.

With the 1960s came a shift in the type of drug used and a corresponding increase in drug usage. The 400 experts who participated in the 1962 Kennedy White House Conference on Drugs coined the term "drug abuse," indicated that the drug field was characterized by inadequate information and misinformation, supported the use of civil commitment to allow medical treatment of drug abuse, and fostered the initiation of projects to address the social problems of delinquency and poverty.

Between 1964 and 1970, youths across America were becoming drug conscious. Studies on LSD were conducted at Harvard, marijuana was openly smoked on many college campuses, and for the first time there were active pro-drug advocates (Mandel & Feldman, 1986). Drugs were used for "getting in touch" with one's self, for improved socialization, and for enhancing one's senses and realms of awareness. Young middle-class White youth had discovered the "information gap" (which some called the generation gap) between the reality of drugs and what they had been told (Mandel & Feldman).

This was the period of the civil rights movement, sit-ins, freedom rides, mass demonstrations, and the beginning of the Vietnam War and draft resistance. Four students were killed by the National Guard during an antiwar demonstration at Kent State University. Students battled with police at Berkeley, and at Jackson State University police fired on students who were demonstrating against discrimination. The larger conventional culture showed that it was willing to use force to control youth, protests, and drug use.

By 1970 the flower children of 1967 had trouble handling the drugs they had played with, and many were now burned-out speed freaks or heroin addicts. New drugs were hitting the streets and their potency and effects were unknown and often frightening. There were overdoses, admissions to emergency rooms, and bad trips. Between 1963 and 1969 the arrest of teens under the age of 18 for drugs increased fourfold. There was a drastic increase in arrests among Whites, and inner-city minority youth shifted away from using heavy addicting substances to more controlled use of drugs. There was a flagrant "disregard of drug laws by large numbers of young people who were not all members of the under privileged and criminal classes" (Ray & Ksir, 1987, p. 42).

In 1969 Richard Nixon proclaimed a "War on Drugs" and increased the federal anti-drug budget from $40 million in 1969 to $750 million in 1973. Half of this was to go to law enforcement and half to treatment programs. The War on Drugs was an uphill battle, with drugs about equal to alcohol in popularity among adolescents. In many ways the use of drugs had been normalized and no longer was seen as deviant behavior by youth. During each year in the 1970s, however, 49% to 57% of those arrested for drugs were under the age of 21. Arrests for marijuana varied from 62% to 72% of teenagers, with the arrest rates remaining highest for Black men (Mandel & Feldman, 1986).

The present law of the land is the Controlled Substances Act of 1970. Besides expanding the role of community mental health centers and public health service hospitals in the treatment of drug abuse, it authorized the development of drug education materials and workshops for professionals as well as school personnel. It also established maximum penalties for manufacturing/distributing and for possession of drugs categorized into five schedules. For example, a second offense of selling cocaine entails a maximum prison term of 30 years, a fine up to $50,000, and 6 years' probation after release from prison (Ray & Ksir, 1987).

The drug-related arrest rates among young Whites is declining. In 1983 it was approximately half of the 1978 rate. In their study of seniors' use rates between 1975 and 1983, Johnston et al. (1984) reported decreases both in use of marijuana in the last 30 days (in 1978, 37% responded in the affirmative and in 1983, only 25% answered in the affirmative) and in the daily use of marijuana (11% in 1978 and 5.5% in 1983). Similar decreases were found in the use of sedatives, inhalants, tranquilizers, and hallucinogens. In contrast, the use of cocaine and stimulants has increased steadily.

Cocaine has become the drug of the 1980s. Until recently, "coke" was considered reasonably safe and nonaddictive and seemed to be the drug for a health conscious, upwardly mobile, politically conservative generation. That cocaine is not safe has been verified by the deaths of comedian John Belushi and basketball star Len Bias. The criminal penalties for selling cocaine demonstrate a get-tough attitude. That our society disapproves of drugs and is willing to enforce drug laws is evident. Although youth may not be alarmed at someone smoking a joint or possessing several ounces of marijuana, the *Hutto v. Davis* (1982) ruling testifies to the feeling of those representing the nation. Davis was arrested for possession of 9 ounces of marijuana, was convicted on two counts of possession with intent to sell, and was sentenced to 40 years in jail. He appealed his sentence as being cruel and unusual punishment, but the U.S. Supreme Court ruled against him (Inciardi, 1986).

It is evident that everyone should know the drug laws of his or her state. For example, growing marijuana in the privacy of your home is legal in Alaska but can result in a 2-year prison term and a $500 fine in Delaware. The local library is a useful resource for state criminal codes and local drug laws. In addition, teens and their parents need to be aware of the rights of minors when arrested. As a result of *In re Gault* (1967), juveniles have a right to a notice of the charges, a right to counsel, a right to confront and cross-examine witnesses, privilege against self-incrimination, a right to a transcript of the legal proceedings, and a right to an appellate review. Minors do *not* have a right to bail or to a jury trial.

The Psychophysiology of Drugs

Beyond knowing how drug abuse has become such a prevalent social problem and how our legal system is attempting to control drug use, to be at all knowledgeable about substance abuse one needs to have a basic understanding of how drugs affect the body. No matter what drug is taken—aspirin for a headache or cocaine to feel high—the drug must go through several phases. First, it has to be taken into the body, or *absorbed*, and then it is distributed, or *transported* to the part of the body where it will produce its effects. The drug then combines with the body part to exert its *action*. The body then *metabolizes* the drug, which stops its action, and finally, the drug is *excreted*. For some drugs these five phases occur in a predictable manner and in a short period of time. For other substances, the process is erratic and can occur over an extended time period. This is particularly true when one considers a drug's half-life.

Drugs are taken into the body in several different ways, the most common being orally. When drugs are swallowed, they are absorbed through the intestinal walls into the bloodstream. Alcohol, sedatives, and barbiturates, for instance, are taken orally. Marijuana, nicotine, and inhalants are smoked/inhaled and enter the bloodstream through the lungs. Heroin is injected directly into the vein. Snorting is the preferred method of taking cocaine, which is then absorbed through the mucous membranes.

The blood carries drugs to all parts of the body. Because *all* drugs have side effects, we cannot be exactly sure what physiological and behavioral reactions will result from taking a drug. We do know that the effects of a drug depend on many variables including the type, potency, and purity of the drug, the contaminant used to cut the drug, the personality of the user, and the social environment in which the drug is taken. Also, an individual's physiology must be considered, especially the nervous system.

The nervous system is made up of the central nervous system (CNS), the somatic system, and the autonomic nervous system (ANS). The CNS is composed of the brain and the spinal cord and is responsible for such activities as information processing, memory, learning, and activity coordination. Sensory nerves come into the CNS and motor nerves go out. The somatic system interacts with the CNS and controls "voluntary" actions. In contrast, the ANS, which is made up of the sympathetic and parasympathetic systems, controls "involuntary" actions such as heartbeat, digestion, and breathing. Most psychoactive drugs have a significant direct influence on the ANS (Ray & Ksir, 1987).

The chemical messengers that carry information throughout the body can be classified as hormones or neurotransmitters. Our glands release hormones directly into the blood, and neurotransmitters serve as signals within the CNS. How drugs affect hormones can be illustrated in the relationship between the pituitary gland and urination. To help the body maintain homeostasis, the pituitary releases vesopressin when there is a drop in blood pressure. Vesopressin causes the kidneys to release less urine. When alcohol is introduced into the body, the release of vesopressin is inhibited and the amount of urine released by the kidneys is increased. It is this chemical process that causes us to have to go to the bathroom so frequently when we are consuming alcohol, not only because we are drinking liquids. It is also worth noting that in this example, because alcohol causes a decrease in blood pressure, the total decrease in blood pressure is compounded.

Although drugs do affect the actions of hormones, they exert their major impact on the neurotransmitters and their chemical pathways in the CNS. The major neurotransmitters affected by psychoactive drugs are acetylcholine, norepinephrine, dopamine, serotonin, GABA, and endorphins. These neurotransmitters function at the synapse between the axon of one neuron and the receptors of a second neuron. Chains of neurons form the chemical pathways in the brain that are affected by drugs (Goldberg, 1982). Just as different neurotransmitters are affected differently by different drugs, so are parts of the brain. Drugs disrupt neural transmissions; however, the exact process for many drugs is a matter of speculation (Lewis, Dana, & Blevins, 1988).

A brief overview of some of the major structures of the brain might help to clarify the intricate interactions among drugs, neurotransmitters, the brain, and behavior. These structures are (Ray & Ksir, 1987):

1. Cerebral cortex—controls reasoning, language, and sensory discrimination;
2. Basal ganglia—maintains good muscle tone;
3. Hypothalamus—involved in feeding, drinking, temperature, and sex;
4. Limbic system—involved in emotions, physical activity, and memory for location;
5. Medial forebrain bundle—pleasure center; tells us when something feels good, i.e., orgasms;
6. Brainstem—vomiting and respiratory center; and
7. Medulla oblongata—seat of aggression.

When the chemical pathways in these various regions of the brain are invaded by drugs that excite, inhibit, or block the actions of a neurotransmitter, the brain and related behaviors are influenced. For instance, cocaine is believed to block the reuptake of norepinephrine and dopamine at the receptors, and the prolonged presence of norepinephrine in the synapsis elevates mood, producing a feeling of euphoria.

Although research on the interaction of drugs, neurotransmitters, and behavior is just beginning to uncover these complex relationships, we do know that psychoactive drugs affect the chemical pathways. In the basal ganglia, tranquilizers block the reuptake of dopamine, and abuse can result in muscle rigidity. Similarly, dopamine in the medial forebrain bundle is affected by psychoactive drugs and increases one's sense of experiencing pleasure. Nerve gas inhibits the metabolization of acetylcholine, which can cause respiration to slow or to cease (the brainstem is the primary site of action). Under the influence of PCP or angel dust, violent and bizarre aggressive behaviors often occur. This reaction may be due partially to the interaction of the angel dust with the neurotransmitters in the medulla oblongata.

It is evident that drugs do not simply make one feel better. They interfere with the normal functioning of the nervous system as well as other organs in the body. When drugs are abused and overused and when drugs are combined, the effects can be deadly. The two greatest dangers are respiratory failure and cardiac arrest. Those who combine alcohol with sedatives, barbiturates, or tranquilizers are particularly at risk for respiratory failure—they will just stop breathing. No drug is free of toxic effects; some are minor but others are deadly (Julien, 1978).

The point being made is that to be a wise user of drugs, if one chooses to use drugs, then one should be aware of the multiplicity of effects they create. Every drug has side effects, but research has not yet discovered the many influences these side effects can have physiologically or psychologically.

Individual Drugs

Now that a variety of perspectives on the global problem of substance abuse have been presented, it is time to focus on some of the drugs that are abused by adolescents. The three chosen for a brief overview are alcohol, marijuana, and inhalants.

Alcohol

As previously noted, alcohol was the first drug regulated in the United States. America's one attempt at alcohol prohibition in 1920 failed because many citizens obtained alcohol illegally. The Eighteenth Amendment, the Prohibition Amendment, was repealed in 1933. The trend has been to relax the laws on intoxicating beverages; however, with the steady increase in death due to driving while intoxicated (DWI), Congress authorized the withholding of federal highway funds from any state that did not raise its legal drinking age to 21 by 1986.

The two alcoholic beverages most heavily consumed by Americans are beer and wine. It is estimated that 24 gallons of beer, 2 gallons of distilled spirits, and over 2 gallons of wine for each man, woman, and child are sold per year, with sales of wine steadily increasing (Ray & Ksir, 1987).

As Schonberg and Schnoll (1986) pointed out, alcohol and marijuana are the drugs most frequently abused by adolescents. In 1983 at least 93% of a large national sample of seniors reported having drunk alcohol, 5.7% indicated daily drinking, and 41% claimed occasional binging (Johnston et al., 1984). It is an established fact that DWI is the leading cause of death among teenagers. Alcohol abuse is a major teen substance abuse problem.

When consumed, alcohol functions as a depressant. Because it is almost completely metabolized and the rate of oxidation is slow, alcohol has a long duration of action that cannot be controlled (Ray & Ksir, 1987). When the blood alcohol level (BAL) is .05%, there is lower alertness, relaxing of inhibitions, impaired judgment, and usually a sense of feeling good. As the BAL increases, judgment ability declines, reaction time is slowed, and both sensory and motor capabilities are impaired. Intoxication is officially reached at .20 BAL, stupor is reached at .30, and .35 is the minimal level that can result in death from intoxication (Ray & Ksir, 1987).

Like any depressant, alcohol affects the CNS, and in large doses can cause respiratory failure and death. It is also known that the vomiting reflex (controlled by the brainstem) can be activated at .12% BAL unless the drinking is slow and steady, which causes a depression of this reflex. Along with these and other brain changes, there are also cognitive and behavioral changes. There is a lower level of blood flow to the brain, which lowers levels of oxygen, nutrient use, and waste removal. In addition, changes in cortical functions result in behavioral changes. The more rapid the intake of alcohol, the greater the behavioral changes as one becomes less inhibited.

When a woman drinks heavily during pregnancy, the unborn baby can be at risk for fetal alcohol syndrome, which causes physical and behavioral abnormalities in the fetus. Among women who are heavy drinkers, spontaneous abortions are twice as likely (Ray & Ksir, 1987).

Physical damage due to alcohol use is rare in adolescents only because they have probably not been abusing for a long enough period of time. With prolonged abuse, however, gastritis with hemorrhaging and inflamation of the pancreas can result (Schonberg & Schnoll, 1986). Bleeding, severe vomiting, and changes in the blood can necessitate hospitalization. Chronic alcoholism in adults can result in chronic liver disease, inflammation of various nerves, and impaired memory (Schonberg & Schnoll). Withdrawal symptoms for teens who have been heavy alcohol users include perspiring, agitation, brief seizures, tremors, and disorientation.

Alcohol abuse is currently the most significant substance abuse problem among adolescents. It negatively affects cognitions, behaviors, and one's body, and has been linked to increased crime, violence, and suicide. Heavy drinking by teens who are pregnant can be dangerous for the baby and for the teenager herself.

Marijuana

Although marijuana is about equal to alcohol in popularity, even less is known about its effects. From 1937 to 1971 it was legally classified as a narcotic, and in large doses, it can produce hallucinogenic effects. Since the late 1960s, however, society has been far more concerned with the more potent and dangerous substances appearing on the black market than with marijuana.

Marijuana and hashish come from the cannabis plant and get their psychoactive effects from THC (tetrahydrocannabinal). Grades or types of marijuana include regular marijuana, which is 2% to 5% THC, sensimilla, which contains about 8% THC, and hashish, which can be up to 50% THC if made into hash oil.

When marijuana is smoked, the THC is rapidly absorbed into the blood. While producing a sedating effect and causing an enjoyable, dreamy high, marijuana is thought to alter the metabolization of serotonin and dopamine. Schonberg and Schnoll (1986) cited considerable research on the negative effects of marijuana on brain, cardiovascular, pulmonary, endocrine, and psychological functioning. Causing short-term memory loss and depressing one's ability to learn, marijuana smoking has been linked to the "amotivational syndrome" where smokers are lethargic, lack motivation, and are content to do nothing. This becomes a special concern for youth who use marijuana before or during the school day in that they are impairing both their desire and ability to learn. The long half-life of marijuana means that a daily smoker may be continually high because the marijuana is never out of the system, and this further contributes to the amotivational syndrome.

Many of the effects of smoking marijuana are similar to those of drinking alcohol. In addition to red eyes, there are lowered secretions of sex hormones, impaired motor coordination, reaction time, and sensory perception, and decreased ability to follow moving objects. With the poorer motor coordination and distorted time and distance perceptions, driving under the influence of marijuana presents the same safety risks as driving under the influence of alcohol. In fact, marijuana use is considered by many to be the second leading cause of death or injury in car accidents among adolescents.

Although there is no current research to indicate that a physical addiction to marijuana occurs, this may be because the existing research on the effects of marijuana is in its infancy. There is increasing belief that marijuana affects the lungs in a manner similar to tobacco, which often results in cancer. Chronic smoking of marijuana does impair air flow in and out of the lungs, and only long-term research will be able to verify the relationship between marijuana smoking and cancer.

There are many advocates for marijuana, and also many who believe they should publicize every evil related to marijuana, whether backed by research or not. Initial research has shown that its effects are not harmless, but neither are they devastating, and that the primary concern is for women using marijuana during pregnancy and for the psychosocial, educational, and physical development of adolescents who engage in daily heavy use. As Ray and Ksir (1987) pointed out, there is no area of science where emotion about the issue has played such a heavy and influential role as in the smoking of marijuana.

Inhalants

Young adolescents between the ages of 11 and 15 are the primary users of inhalants, although use of inhalants has steadily declined with the increase of marijuana use. Airplane glue, gasoline, cleaning fluids, and aerosols are the compounds these young teenagers sniff. Each of these compounds contains volatile hydrocarbons that cause a strong short-lived euphoric high. Symptoms of inhalant use include "lack of coordination, restlessness, excitement, confusion, disorientation, difficulty in walking (ataxia), delirium, and coma" (Schonberg & Schnoll, 1986, p. 54). While repeated use can result in giddiness, dizziness, and hallucinations, long-term use can cause brain, liver, kidney, and nerve damage (Schonberg & Schnoll).

A syndrome called "sudden sniffing death" can occur when inhalant abuse is immediately followed by excessive exercise and stress. Although young teens may enjoy the giddy high that is connected with sniffing, they are again playing with a potentially dangerous substance.

Prevention and Education

What most concerned adults are asking themselves is how they can intervene to prevent teenagers from using drugs and how they can intervene to decrease or stop substance abuse that is already occurring. Two primary milieus for prevention/intervention are schools and the family. In addition, a variety of treatment programs address substance abuse.

Schools

The primary responsibility for substance abuse prevention and education has fallen on the public schools. Yet, research (Goodstadt, 1980) has shown that just giving students drug education and information (often misinformation) has failed to deter drug use. During the 1970s, educators tried to fight drug abuse by employing affective education through the use of such approaches as Parent Effectiveness Training (Gordon, 1970), the DUSO Kit (Dinkmeyer, 1973), and the Magic Circle technique (Ball, 1974). These seemed not to have had a significant positive impact on adolescent drug use. In 1982, Horan and Williams were able to demonstrate that general assertiveness training and drug-specific assertiveness training positively influenced junior high school students' willingness not to use alcohol and marijuana. At a 3-year follow-up, these students reported less actual drug use and demonstrated higher levels of assertiveness.

A variety of educational programs that attempt to address the teen drug problem have evolved in the last decade. Nancy Reagan is the prime mover for the "Just Say No" approach, which tells kids just to refuse to even try drugs. This, however, is a narrow approach to a multidimensional, complex problem.

Research on the effectiveness of the "Here's Looking at You Two" curriculum that emphasizes increasing self-esteem, reducing peer influence, and providing drug information has been promising (Swisher, Nesselroade, & Tatanish, 1985). Unlike the Here's Looking at You Two curriculum, most other curriculum packages either are not supported by empirical research or have not been systematically evaluated. A few of the drug intervention/prevention curricula that are commercially available include: Children Are People; All Stars; 8:30 Monday Morning; Dare; Lions/Quest Program—Skills for Adolescents; Project Pride; and Get High on Yourself. Most of these attempt to address the drug problem from multiple perspectives. In addition, groups such as Mothers Against

Drunk Driving (M.A.D.D.) and Students Against Drunk Driving (S.A.D.D.) have become increasingly active in the fight against drugs.

Regardless of the school curriculum chosen or locally developed, it would seem appropriate that it attempt to address what research has consistently shown to be the primary factors in the etiology of substance abuse. These factors are peer use of illicit substances (Kandel & Yamaguchi, 1985), peer pressure (Brook, Whiteman, & Gordon, 1983; Brook, Whiteman, Gordon, Nomura, & Brook, 1986), early antisocial behavior (Hawkins, Lishner, & Catalano, 1985), troubled families (Hawkins et al.; Shore, 1985) and deficient intrapersonal qualities such as positive self-concept. Incorporating these should enhance prevention efforts.

The Family

The role of the family in adolescent drug abuse has been widely recognized. Certain family characteristics place an adolescent at risk. Some of the most documented are the abusive family, the alcoholic family, a single-parent family, a family where the children are latchkey children, a blended family, and a family with inconsistent limit setting and rules for behavior.

Substance abuse does not occur suddenly. It is often the result of many factors including feelings of low self-esteem and inadequacy, ineffective coping skills, and poor decision-making skills. Most parents try to raise their children with love and caring; however, too many teens have not learned to love themselves and to cope with life's problems in a constructive way, and instead turn to drugs to escape their problems. Glickman and Utada (1983) found a dramatic degree of conflict, misunderstanding, and disagreement between teens who were seriously involved in drugs and their parents. These teenagers reported that their parents objected to their friends (77%), were disappointed in them (69%), complained about them (64%), and did not trust them (63%). For these teens, the quality of their relationship with their parents was poor and communication was defensive and certainly not honest.

If parents suspect that their child is using drugs, the National Institute on Drug Abuse (NIDA) (1984) advised parents to tell the child about their concern and why the drug is harmful. In addition, they need to communicate that they are opposed to any drug use and that they intend to enforce that position. Parents need to be: "*Understanding* (I realize you're under a lot of pressure from friends to use drugs); *Firm* (As your parent I cannot allow you to engage in harmful activities); *Self-examining* (Are my own alcohol and drug consumption habits exerting a bad influence on my child?)" (NIDA, pp. 4–5). What parents should not be is sarcastic, accusatory, sympathy-seeking, and self-blaming.

because these behaviors tend to make a child defensive and likely to tune the parent out (NIDA).

A confrontation with a child regarding drugs can be difficult and charged with emotions; however, parents can control this by remaining calm, open, loving, and firm. Parents need to listen to their children and not only give advice. One of the keys to helping a child grow up is to teach the child how to make responsible decisions, to accept the consequences of those decisions, and love themselves. This cannot be accomplished quickly but is a slow process that is nurtured by parental support, love, concern, and understanding. Parents need to know the difference between firmness and punishment. Children respect fair limits that take into consideration their maturity and behaviors. Consistency in limit setting helps a child understand the acceptable parameters for behavior and what will consistently earn approval or disapproval. Parents need to be in charge in a loving, supportive manner. Although adolescence is a time of seeking independence, autonomy, and self-identity, most teens still need and want a fair amount of parental direction as well as nurturing and caring.

Treatment Programs

If treatment rather than prevention is required, it often occurs in a more structured setting such as a treatment program. Treatment programs vary in type and setting for services provided. Settings include short-term inpatient crisis care, inpatient programs, day-care programs, residential treatment, halfway houses, and outpatient treatment programs. Although all programs make extensive use of group and individual therapy, they also "require some parental and/or familial involvement in the program and attempt to provide family counseling" in an effort to focus on the "underlying problems" in the family milieu (Kusnetz, 1986, p. 151). The more actively involved and supportive the family, the greater the chance of recovery for the substance abuser, if the abuser is motivated to stop the abuse. More successful adolescents recognize that they have a problem and want to participate in the treatment (Kusnetz). Those teenagers who are apt to be less successful are referred by the criminal justice system, have used drugs for a longer time and are more immersed in the drug culture, come from families where the adults are substance abusers, and have histories of violence and gang involvement (Kusnetz). However, regardless of the background of the abuser, motivation to change on the part of the teen and his or her family is the key to improvement.

Everyone has different ideas on how to solve the drug problem. These vary from drug legalization to the execution of dealers. What we are doing now in our legal system does not seem to be working. On the other hand, strictly social interventions are not enough either. As mentioned earlier, any intervention has to include multiple foci—not the least of which is the family (Daroff, Marks, & Friedman, 1986). In addition, teens and preteens need to receive accurate information on the effects of drugs—not only scare tactics designed to frighten them into avoiding drugs. This type of tactic perpetuates the "information gap" the counterculture of the 1960s experienced. We also need to consider the possibility that we will never totally stop substance *use*, and that perhaps we should prepare our children and adolescents to be wise decision makers with respect to taking drugs and avoiding substance *abuse*.

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Part IV

COMBATING THE ULTIMATE RISK: SCHOOL DROPOUT

Chapter 14

UNDERSTANDING AND PREVENTING SCHOOL DROPOUT

James W. Kushman and Paula Kinney

School dropout is a highly visible sign of a society that has failed to prepare its youth for successful transition into adulthood. It is an issue that should be of great concern to school and community counselors working with young people and their families. School dropout is a problem that has recently gained much public attention. Ironically, the heightened concern about students not completing school comes at a time when long-term demographic trends show a decline in the high school dropout rate. Census data indicate that among 25 to 29 year olds, 16% of the U.S. population in 1980 did not complete high school compared to a noncompletion rate of 60% in 1940. Although this may give us some comfort, state-level statistics show a rather different short-term trend with high school noncompletion rates creeping upward beginning in the early 1970s (Rumberger, 1987).[1]

It is clear that the problem does not affect all groups equally. Poor and minority students tend to experience the highest dropout rates, and boys show higher rates than girls. Figures from the U.S. Department of Education's High School and Beyond national sample of 1980 high school sophomores indicate that 19% of Hispanics and 17% of Blacks drop out of school by their senior year compared to 13% of Whites. Dropout rates by socioeconomic status (defined by family income and parents' occupation and educational background) show the top half of the social stratum with a dropout rate of 18% compared to a rate of 35% for low and low-middle socioeconomic students (High School and Beyond figures as reported by U.S. General Accounting Office (GAO), 1986). Given these disparities, it is not at all surprising that the dropout problem is most concentrated in large urban areas where poor and minority students tend to live. It is not uncommon to hear of dropout rates in some urban schools in cities like New York or Detroit climbing as high as 80%.

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[1] Estimates of the dropout rate can vary to a surprising degree depending on how "dropout" is defined and measured. Sources of dropout statistics include special U.S. census surveys, large national samples of youth who are tracked over time, and data compiled by state departments of education and local school districts. As yet, there is no agreed-upon method for estimating the problem. The reader is cautioned against comparing dropout rates from different sources.

There are both moral and economic implications of students dropping out of school. First, a society based on humanistic and democratic ideals cannot simply sacrifice or write off large numbers of youth who, because of their failure in school, gravely limit their potential and future well-being. Second, there are serious economic consequences of an undereducated population. Large numbers of dropouts weaken the economy because they are unprepared to work and because they place a burden on unemployment and welfare services, not to mention the criminal justice system. Dropouts run the risk of becoming drains on society rather than productive and contributing members. Census and labor market surveys indicate that today's high school dropouts are two to three times more likely to be unemployed than high school graduates and are also more likely to find themselves in low-level jobs (GAO, 1986). The problem becomes exacerbated as we move further into the so-called postindustrial economy where important jobs will require more education and more problem-solving skills. Coupled with the changing nature of work is the fact that ethnic groups such as Hispanics with high dropout rates will continue to compose a greater share of the work force.

That young people do not complete school is both a moral and an economic tragedy. In a general sense, counselors can play an important role by helping at-risk youth realize the tragedies that may lie ahead. Counselors must help at-risk youth see the connections between present choices to stay in or drop out of school and future personal consequences such as wasted lives, unemployment, and involvement in crime. This does not require moralizing, but providing young people with a realistic picture of the consequences of not completing their education. Interestingly, youth who drop out of school tend to experience increased self-esteem at first, but over time, these feelings tend to be replaced by great remorse as negative personal consequences are fully realized.

Although the label "dropout" is conveniently applied to large numbers of students who do not finish school, such a label belies the fact that they are a diverse group who leave school under diverse circumstances. The implication is that there is no single cure-all that can be uniformly applied by counselors or educators. Helping potential dropouts requires a clear understanding that the problem is complex and multifaceted. Bickel, Bond, and LeMahieu (1988) pointed out that the term "dropout" itself is potentially misleading because it implies a single decision point to leave school, with the student as the sole decision maker. Such is not always the case. Some students merely "fade out" after a period of feeling alienated from school. Others can be subtly or not so subtly "pushed out" by school personnel who do not want to deal with them any longer. Still others are "pulled out" either by more important demands on their time such as parenting or supporting elderly family members, or by negative community influences such as gangs. It is also important to remember that some students leave school but do return, perhaps only to drop out again. As yet, a precise typology of early school leavers has not been developed. It is clear, however, that different students leave school under different circumstances and for varied reasons, even students within the same school.

In this chapter, we will unravel some of the complexity of the dropout problem in the hopes of making it a manageable issue with which counselors can deal. We will talk about four points of intervention throughout the chapter. Two are areas that counselors are perhaps more familiar with: the student and the family. Two other important areas, however, cannot be overlooked: the school and the community. Two broad strategies of intervention will be discussed, one that focuses on the individual and one that focuses on the larger system in which the individual functions.

The rest of this chapter is divided into three major sections. The first section will discuss the characteristics of school leavers, the visible warning signs, and the presumed underlying causes based on recent research. In the second section, a less abstract discussion of two practical intervention strategies will be presented. These two broad strategies will be called the *clinical approach* and the *systemic approach*. Throughout both of these sections, implications for school and community counselors will be drawn. In the final section, we will summarize and conclude with the larger implications for practice and policy, focusing on the special role of school and community counselors.

Warning Signs and Underlying Causes

A great deal of research over the years has attempted to identify factors related to school dropout. Rumberger (1987), in his recent review, classified the many variables into six categories: demographic, family-related, peer influence, school-related, economic, and individual. Perhaps a more useful distinction for designing counseling interventions is to think of variables as falling into two broad categories: *demographic* *correlates*, which represent the students' more stable background, and *early warning signs*, which represent more immediate and alterable student characteristics.

Demographic Correlates

It has been well documented by now that some racial minorities—Native Americans, Hispanics, and Blacks—are more likely to drop out than Whites and that men are more likely to drop out than women. What factors underlie racial differences? One plausible explanation found to hold merit is social/economic disadvantage, a condition more prevalent among minorities than Whites. Rumberger (1983), using data from the 1979 National Longitudinal Survey of Youth, found that when background and home characteristics such as parents' education and aspirations, income level, number of reading materials in the home, and so forth were held constant, the racial gap in dropout rates virtually disappeared. Another factor is language. Among some groups like Mexican-Americans or Asian-Americans, language differences undoubtedly play a part in school success or failure and, therefore, are another factor to consider in explaining differential dropout rates. Finally, a "cultural differences" argument also has been made to explain why some groups fail in school. This view has been most clearly articulated for Black students. Ogbu (1981, 1986) and Boynkin (1986) hypothesized a deep-seated cultural conflict between the Black experience in the American urban ghetto and in American public schools. The cultural conflict centers around two issues: (1) the devaluation of mainstream education by Black culture and families given the few perceived economic benefits of completing a formal education, and (2) differences between the culturally rooted thinking and behavior styles of Afro-American children and schools that cater to a Euro-American style of behavior and learning. This second point is rather controversial, that is whether unique ethnic styles of learning and cognition actually exist. Shade (1982) reviewed the literature on Afro-American cognitive styles, and although some studies have found specific differences between Blacks and Whites, the evidence is sparse and far from conclusive.

In summary social, ethnic, and cultural background are the major demographic correlates of school dropout. Students who have traditionally not been part of the American mainstream, such as the poor and some ethnic groups, may experience greater difficulties in school. Schools are not always responsive to the needs of different ethnic and cultural groups. Although we do not yet fully understand why some groups drop out more than others, it seems clear that such differences are best understood in terms of underlying factors such as family circumstances, language skills, and cultural differences to which schools have been slow to respond. We live in an increasingly pluralistic society. Counselors working with at-risk youth need to be sensitive to the diversity of backgrounds and cultures from which today's students come.

Early Warning Signs

The factors described above represent relatively stable and unchangeable background characteristics of the individual. Another set of variables are characteristics and circumstances that are more immediate and alterable through educational and counseling strategies. Studies have identified a variety of school and personal factors predictive of dropping out, factors that counselors can view as early warning signs. These variables fall into four categories: poor academic performance, behavior problems, affective characteristics, and personal circumstances.

Poor academic performance is usually evidenced by low grades, low test scores, and being held back one or more grades before high school. School counselors do need to communicate with teachers so that patterns of low performance or academic failure can be identified early. Academic performance is intertwined with behavior and affective problems, with which counselors deal directly. Behavior problems are usually evidenced by disruptive classroom behavior, cutting classes, truancy, and suspension. The affective areas that counselors will most likely have to treat are poor or unrealistic self-concepts and feelings of alienation, that is, feelings of not fitting into the school or classroom. Finally, many student circumstances such as teen pregnancy, teen parenting, having to work, and caring for sick or elderly family members can conflict with school demands. This is an area where counselors can play a critical role in helping students find ways to balance school and outside demands, and in advocating for students who have unique circumstances that require special school or community services such as a teen mother program.

Obviously, some of these factors can occur early in a child's school career, and the question of when to identify potential dropouts is a crucial one. As in other counseling areas, early identification is a delicate matter not to be taken lightly. Although it is desirable from a prevention standpoint to identify potential dropouts as early as possible, caution must be exercised. It is imperative to avoid harsh labels that lead to stereotyping by teachers and other students, and negative self-concepts and lowered aspirations among those so labeled.

How early *can* potential dropouts be identified? Certainly earlier than high school and even as early as the primary grades. A study by

Lloyd (1978) of a group of 1,500 students was able to successfully discriminate school dropouts from high school graduates based on sixth-grade and third-grade student characteristics. For the third-grade analysis, a combination of four factors was found to discriminate dropouts from graduates with 75% accuracy: (1) achievement scores (especially in reading); (2) global ability (IQ test); (3) socioeconomic status and family background characteristics; and (4) retention (nonpromotion) during the first three grades. The same characteristics were found to hold for the sixth-grade analysis, with the addition of school attendance. Although such variables are predictive of dropping out, it is important to keep in mind that they are not foolproof indicators. In Lloyd's discriminant analysis, for example, 25% of the students were misclassified based on third-grade characteristics, pointing out that some students do succeed despite early warning signs to the contrary. And of course success is much more likely when prevention and early intervention measures are taken by counselors and other school staff.

Although identifying individual student risk factors is important to planning and implementing counseling interventions, we do not wish to advocate a "blaming the victim" mentality that such an exercise often becomes; that is, focusing all of the blame on students and their behaviors. One point of view, developed later in this chapter, holds that schools and other institutions should take their share of the responsibility for the dropout problem. Relevant to this argument is an educational issue currently being debated. Educators are beginning to wonder whether new school reforms aimed at raising academic standards are at least partially responsible for increases in school dropout. McDill, Natriello, and Pallas (1987) identified three possible ways in which this might happen. First, a high school curriculum that is narrowly focused on basic skills instruction not only limits student choice but also defines student success in narrow terms. These conditions have the potential to push low performing students out, especially those who enter high school with a long history of academic problems.

A second school reform that might have an adverse effect is increased learning time outside of the school (e.g., assigning more homework, an extended school day). Although time is not a scarce resource for most teenagers, some have legitimate adult demands on their free time such as working to supplement family income, helping with sick relatives, or raising children. Without some concessions for these students, increased academic time demands can become another reason for leaving school. A further complication is that after-school academic time usually takes away from extracurricular activities, activities that may be the only positive attachment to school for students who experience problems in the classroom. With regard to homework, students who live in overcrowded households or have undereducated parents may lack adequate support outside of school to meet increased homework demands. Finally, tougher graduation standards and minimum competency testing (the practice of not graduating students until they demonstrate minimum basic skills in reading, math, and language) also can have obvious adverse effects on students with academic difficulties. If standards are raised, additional assistance is needed for students who cannot easily meet the tougher graduation criteria. Speculation continues about how recent school reforms might adversely affect at-risk students, but there has been no research to directly confirm or deny these suspicions. Nevertheless, it is certainly reasonable to assume that rigid school reforms that fail to take into account the needs of at-risk youth may do more harm than good.

Research Findings of a More Explanatory Nature

Up to now we have described the important correlates of dropping out, but this is far from a deep understanding of the complex and underlying causes of dropout behavior. Three recent studies that have more of an explanatory focus will be presented in some detail. Special attention will be paid to presumed causal factors that are most relevant to planning counseling strategies.

Ekstrom, Goertz, Pollack, and Rock (1986) looked at differences between school stayers and leavers and tried to answer the question of why one student drops out and not another. The study analyzed data from the High School and Beyond national sample of 30,000 high school sophomores and seniors. Behavior and attitude measures were taken of sophomores in 1980 and 2 years later for both graduates and nongraduates. Consistent with research on smaller student samples, it was found that behavior problems and low grades were the major differences between these who graduated and those who did not.

The behavior pattern of the sophomores who eventually dropped out showed less affiliation and more disengagement from school than among those who graduated. Specific behaviors of the dropout group included doing less homework (an average of 2¼ hours per week for dropouts vs. 3½ hours for graduates), participating less in extracurricular activities such as athletics, and more frequently working for pay during their sophomore year, although here the difference between dropouts and graduates was small. An important attitudinal difference regarding work, however, was that dropouts were more likely than graduates to view their current jobs as being more important than school (23% vs. 10%). Other attitudes of dropouts matched their disengaged behaviors. Dropouts expressed more alienation from school life and were less interested and less satisfied with school, their teachers, and their education generally. Dropouts also felt less popular than graduates. An interesting finding was that dropouts tended to have friends who expressed the same feelings of alienation. This suggests the importance of peers in influencing the attitudes and behaviors of at-risk students.

The study by Ekstrom et al. (1986) also tested a causal model using a statistical procedure called path analysis. This model provided evidence that parents and home life play a large role in dropout behavior. The model found that whereas disciplinary problems and low academic performance had the most immediate effect on decisions to stay in or drop out, a lack of family involvement was seemingly an important cause of the school misbehavior and academic problems. Lack of family involvement was evidenced by few educational supports in the home (e.g., reading materials) and parents who were uninvolved in helping students make curriculum choices. It was also found that dropouts were less likely than graduates to discuss their school experiences with parents.

Wehlage and Rutter (1986) also analyzed the High School and Beyond sophomore data. Using a technique called discriminant analysis, selected variables were used to predict membership in three groups: those who had dropped out by their senior year, those who stayed in, and those who were college-bound. Although the first discriminant function reflected traditional findings such as low socioeconomic status, low student expectations, and low academic performance as predictors of dropping out, a second set of variables was also found to be important independently of this first function. The second set of variables showed negative school experiences (most notably, discipline problems) and lifestyle factors like truancy and increased hours spent working outside of school as circumstances that discriminate dropouts from graduates and college-bound students. The authors interpreted these and other findings as suggestive of a dropout process where, for some students, the school experience is very negative and leads to disengagement, alienation, and loss of commitment to the goals of graduating and continuing with education. For these students, schools lack holding power. What is it about school and the school experience that pushes some students out? The next study addressed this very question.

Fine (1986) conducted an in-depth case study of a comprehensive high school in upper Manhattan composed of low-income students who were primarily Black and Hispanic. Although the school was in a poor area of the city, it was characterized as having a good reputation for safety and stability. Fine conducted observations in classrooms and other school settings, looked at student autobiographies, conducted in-home interviews with 30 recent dropouts and 15 who had dropped out 4 years earlier, and administered surveys to 350 ninth graders, some of whom were followed up later. Her results demonstrated how different students in the same school and urban setting expressed different reasons for dropping out. Some were very critical of schooling and its worth in obtaining a job or a good income. Others had to attend to family health or economic needs that interfered with school. Some students simply felt a sense of hopelessness in the midst of poverty and their own school failure. Finally, one group felt pushed or thrown out by school personnel who did not want to deal with them anymore. Clearly there was no single self-reported reason for dropping out, even within the same school and urban environment.

Fine (1986) attempted to identify some of the basic school structural characteristics that may lead to dropout. She described her case study as a school that had a disproportionate share of low-achieving students and had insufficient resources, resulting in overcrowded classrooms. Furthermore, teachers and administrators in this Black and Hispanic school were predominantly White, leading to poor communication and a lack of understanding between teachers and students. Regarding the climate of classrooms from which students were most likely to drop out, Fine reported that:

> Classrooms are organized more around control than conversation, more around the authority of the teacher than autonomy of students, and more around competition than collaboration. When students talk to each other or cooperate it often provokes accusations of cheating from their teachers. (p. 105)

Fine used the term "disempowerment" to explain the process of dropping out. Many teachers reported a sense of disempowerment, felt that no one listened to them, felt that school policy did not reflect what was really important for students, and believed that students could not be helped. Teacher feelings of disempowerment carried over to students, who in turn developed feelings of powerlessness and alienation, and it was those students who eventually dropped out.

The disempowerment hypothesis is consistent with the research findings on the psychological state of dropouts both before and after they leave school. Two important variables here are locus of control and self-esteem, variables investigated in the two earlier studies using the national student database. The High School and Beyond studies (Ekstrom et al., 1986; Wehlage & Rutter, 1986) found that, first, dropouts projected a more external locus of control than did graduates; that is, feelings of having little personal control over what was happening to them. This was found to be especially true among Black dropouts. A second important finding was that the level of self-esteem among dropouts (measured by items such as "I am as able to do things as well as other people") improved once they left school. Although this may seem surprising at first, leaving a situation that has become a source of many negative experiences would surely be accompanied by feelings of relief and even heightened self-esteem as new possibilities are in sight.

Returning to Fine's study of the inner-city high school, she found that most students who left school were highly energized and motivated at first. Among the 30 recent dropouts whom she interviewed, 28 were busily engaged in something 4 months after leaving school. For the most part, they were engaged in legal and productive activities like enrolling in GED programs, applying to trade schools, or working in low-level jobs, but some illegal activities like drug dealing also were reported. Seven of 15 students who had dropped out of the school 4 years earlier were also interviewed, and things were generally not going well for them. Fine concluded that although there may be some initial psychological advantage to leaving school, this advantage is soon lost as negative consequences begin to accumulate.

In summary, the correlates and presumed causes of school dropout involve a set of related variables that cut across the student's experiences and behaviors, the school environment, and support systems outside of the school including parents, peers, and community agencies. There are multiple points where counselors and others must intervene. The important points of intervention are:

1. Student behaviors within the school:
   - Poor academic performance;
   - Cutting classes; and
   - Uninvolvement in school life outside of the classroom.
2. Student behavior outside of school:
   - Truancy;
   - Increased hours spent working or in illegal activities; and
   - Drug and alcohol use.
3. Student affect:
   - Feelings of hopelessness;
   - Not feeling in control of life events; and
   - Lowered self-esteem.
4. Student life circumstances:
   - Teen pregnancy or parenting; and
   - Social and economic hardships that place adult demands on young people.
5. School climate:
   - Quality of teacher-student interactions;
   - Effective but fair school discipline procedures; and

- Accommodations to students who must combine school with work or family responsibilities.

6. Home and family:
   - Parental interest and involvement in the student's school experiences and progress; and
   - Identification of abusive parents.
7. Community:
   - Negative peer influences that can accelerate student disengagement; and
   - Community support programs (e.g., teen mother services) through counseling agencies, churches, and volunteer groups.

Several larger themes overlay the many variables and points of intervention that have been discussed. The first theme is *opportunity to learn*. At-risk students may require more opportunity to learn (that is, more time allowed for learning tasks), given their poor academic performance. Unfortunately, time is a limited resource for some at-risk youth who have legitimate adult responsibilities outside of school such as teen parenting or working. A second theme is *motivation*. Simply having students spend more time in learning tasks will not suffice if they are not motivated to learn. At-risk youth must believe that they can succeed in school and must perceive some present and future value for their hard work if they are to become motivated. A third theme, related to motivation, is *commitment*. Commitment can be viewed as the opposite of alienation, a condition that characterizes many dropouts and their teachers. In order for students to feel committed to school, they need teachers and counselors who are themselves committed to their students and school, and they need to feel involved in school life outside of the classroom. The last theme is *empowerment*. Empowering students with some legitimate responsibilities (e.g., a say in discipline policies, curriculum choices) should lead to increased identification and affiliation with school. Empowering teachers and counselors with the responsibility and decision-making power they need to help students is likewise important.

Preventing School Dropout

Much research has been done to identify the impediments to students who are at risk of dropping out. The question now becomes what to do about students once they are identified as possessing these characteristics. Counselors and school administrators are continually searching for new approaches that will enable them to implement effective strategies that may prevent students from leaving school. Generally, there are two types of approaches that can be employed: the *clinical approach* and the *systemic approach*.

Clinical Approach

The clinical approach is probably the more common and more familiar to counselors because it deals directly with the student. This approach asks the question, "What's wrong with the student?" It begins to look at predictors and indicators intrinsic to the student who risks dropping out of school. In most cases, this approach will address a number of questions in three areas:

1. The home:
    - Does the student come from a low-income family, a poorly educated family, or a family with serious financial problems?
    - Does the student come from a dysfunctional family where there is dissention, alcohol, or drugs?
    - Were the parents or are the siblings dropouts?
    - Is the student emotionally or physically neglected or abused in the home?
2. Personal traits or circumstances:
    - Does the student have low self-esteem?
    - Does the student lack motivation?
    - Does the student exhibit boredom?
    - Is the student pregnant?
    - Is the student addicted to drugs or alcohol?
3. School behaviors:
    - Is the student frequently absent?
    - Is there a lack of interest in schoolwork?
    - Does the student exhibit hostility, unruliness, passivity, or apathy?
    - Has the student repeated grades?
    - Does the student have difficulty with reading, math, and communication skills, especially in the early grades?

The astute counselor must zero in on these factors and begin to develop a planned, coordinated response of prevention and treatment. Several educational and counseling strategies have been tried over the years to address the problems students who are at risk of dropping out of school face, or to address the needs of students who have already dropped out.

Special education has been one approach for the student whose behavior and poor academic performance indicate that he or she needs something educationally different than the regular program. Special education may have saved some students from dropping out of school because of individualized instruction and small class size. However, for other special education students who truly did not have a handicapping learning condition but possessed other factors that adversely affected their learning, special education may have led them to feel alienated, unworthy, and even more of a failure. Counselors should be aware that with special education students or other special populations, work may have to be done to build self-concepts.

Remediation has been another method for addressing the academic problems students experience in school. Many students who are at risk of dropping out may have been retained in at least one grade. Another remedial approach is ability grouping that places underachievers in slower classrooms so that they might catch up. The problem with ability grouping is that students in slow classrooms experience embarrassment and lowered self-esteem, and often, as a result, behavioral problems begin to erupt. Research has shown that placing students who have academic or behavioral problems together in the same classroom will not improve student achievement or self-concept (Kulik & Kulik, 1982). On the contrary, ability grouping may worsen the situation because a social hierarchy is inadvertently set up in the school that negatively stigmatizes low-group students (Rosenbaum, 1980; Winn & Wilson, 1983). However, when low-ability students are mixed with average and high-ability students, negative stereotypes are avoided and the slow students may become more challenged and improve. It is important to point out that remedial strategies can be effective if these negative consequences are foreseen and dealt with; for example, by grouping students for only part of the day and by providing a lot of individualized instruction within the classroom so that low students can succeed at achievable academic goals. Students tutoring other students, or cooperative learning, is another effective strategy for students who need remediation.

One of the most successful approaches for addressing the needs of at-risk students is to place them in an alternative program if such programs are available. "Alternative program" is a label for a variety of nontraditional elementary and high school programs that are usually housed in separate buildings away from the traditional school. There is no single model alternative program, nor do these programs always serve the same population. One type of alternative program is the special school for high-risk students who have been repeatedly suspended or otherwise do not seem to fit in at conventional schools. Alternative schools of this type employ individualized academics along with counseling services that are designed to better meet the needs of at-risk youth. Although alternative schools aim to change the student and therefore come under the clinical approach, these schools also represent the systemic approach (which will be discussed in the next section) because the school and its program are structured around the needs of students. The alternative school is perhaps the best contemporary example of combining the clinical and systemic approaches.

An effective alternative program will better meet the needs of most at-risk youth because of smaller school and class size and more individualized personal attention, including counseling services. Other characteristics of a successful alternative program include autonomy from the regular school, highly committed staff, nontraditional and varied curricula, experiential education involving work in community settings, and a supportive atmosphere resembling a family setting (Wehlage, 1983). Alternative programs can provide a safe, caring environment which, for many at-risk youth, may be the only place where they receive positive attention. For some students, the alternative school may be the only stable "home" or "family" they have.

Alternative programs have been regarded as a highly successful approach (see Institute for Educational Leadership, 1986), but the research findings on the effectiveness of such programs have been mixed partly because of poor research methods. At-risk students tend to prefer alternative programs to regular school and feel better about themselves in a learning environment that provides more personalized student-teacher relationships (Educational Research Services, 1977). Beyond this general effect, however, we do not yet understand how different alternative interventions affect different types of at-risk youth, especially with regard to the myriad counseling interventions that an alternative school might use. Evidence shows behavior modification to be effective with students who act out, but other types of counseling modalities have undergone little systematic research (McDill et al., 1987).

One decision that counselors in both regular and alternative schools may face is whether to treat students in the school setting or outside. There can be some advantages to counseling retreats that temporarily remove students from a school environment that is unpleasant or not conducive to positive change, but isolating students from the school in order to treat them may have unintended negative effects. An interesting study by Catterall (1987) of a 4-day high school counseling retreat found no positive effects of the retreat, and even some slight negative effects when program participants were compared to nonprogram controls. The retreat involved self-concept building activities; skills training in teamwork, decision making, goal setting, and academic learning; and challenge and relaxation exercises. The study found that students who participated in the retreat perceived significantly more negative labeling by teachers and less social bonding to teachers than did controls 4 weeks after the program. One plausible explanation for these unintended effects is that retreat programs may serve to increase student isolation and alienation from the school. Such programs may reinforce student bonding to other at-risk youth and weaken ties with teachers and school.

It would be remiss to discuss clinical approaches without stressing the importance of collaborative relationships between schools and social service agencies. At-risk students will, in many cases, have other problems besides experiencing failure and frustration in school, as the research reviewed earlier clearly indicates. Behavioral or psychological indicators that students exhibit in school may alert counselors to other problems in the student's life. It is important that the whole student be addressed and not only behavior within the school. In some school districts, student service centers have been implemented in order to personalize counseling and support services that are essential to address fully the needs of at-risk youth. If student services are not available via the school district, counselors and administrators should take steps to bring these services to the schools or provide transportation for students to community agencies. Support and counseling services are also important for parents of at-risk youth who may be contributing to the students' failure in school.

All the above methods can have positive effects on students who are experiencing failure, frustration, and unhappiness in school. However, the clinical approach in and of itself may not solve the problems of the potential school dropout. Although the intention may be to help students, some clinical interventions carry a negative stigma that can result in these programs doing as much harm as good. For example, students who are placed in slow classrooms for several consecutive years are in danger of being labeled "learning disabled" throughout the rest of their school career. Although school systems have begun looking more closely at mainstreaming special education students, the numbers of students who are moved into regular programs are still too few, especially for certain groups such as Black adolescents. Another concern is equity. In many instances, students who are placed in special programs, including alternative education, may receive a watered-down version of the curriculum, leaving them unprepared for postsecondary education or the working world. Expectations may be lowered for students who are enrolled in special programs, and then failure can become a self-fulfilling prophecy.

In summary, there are several limitations to the clinical approach. First, the goal of some counseling programs is simply to help at-risk students feel good about themselves rather than improving academic performance. It is important to remember that students will generally feel good about themselves if they are academically successful. A more basic limitation of the clinical approach is that it assumes the problem lies solely within the student. Efforts are geared toward "fixing" the student so that he or she will function better in the traditional school. Too much time and energy can be spent on trying to change unalterable or difficult-to-change factors outside of the school such as ethnic and cultural values, dysfunctional families, and the effects of poverty. The school takes on the role of becoming a social rather than an educational agency. A more fruitful approach for treating the *whole* student is the systemic approach that is discussed next.

Systemic Approach

The systemic approach focuses on changing the educational system to meet the needs of at-risk students. It is more difficult to implement than the clinical approach and therefore one that many school districts shy away from. Very high levels of commitment from the community, the school board, the superintendent, principals, staff, parents, and students are required for the systemic approach to work.

The systemic approach recognizes the unalterable or difficult-to-change factors like race and poverty, but does not allow these factors to become an excuse or roadblock from successfully educating all students. Unalterable factors are taken into consideration in designing a school that is responsive to the whole student and to all students. For many at-risk youth, school is a place where they feel isolated and discouraged. Because of their circumstances and backgrounds (e.g., having to work to support self or family, feeling culturally or racially isolated, possessing a learning style that does not mesh with traditional ways of teaching), school can become a place of frustration for many students. In the case of female students who become pregnant or are already teen mothers, dropping out may be the only solution if accommodations cannot be made for their educational and personal needs (e.g., class scheduling, day care and prenatal care, etc.). For most young people, the only way to handle an extremely frustrating situation is to rebel and act out, or simply to leave the situation, which many students do when they drop out of school.

A progressive school district that supports the systemic approach recognizes the fact that with the diverse demographic makeup of the total student body, it is necessary to design a flexible system around the needs of students. Schools become more student-centered. Factors within the school that can impede student success are addressed. There are four major factors within a school that, if not structured for the benefit of students, can serve as obstructions for at-risk students.

1. Organizational structure. The organizational structure of the school can be one of the major barriers to student success. To begin with, many urban schools are simply too large. Students who attend a large school with large class sizes tend to feel overwhelmed and defeated, especially in transition years such as the sixth and ninth grades. The at-risk student may already be skeptical as he or she enters middle school or high school. These students need to feel accepted on a personal basis and need to feel involved, which is almost impossible to accomplish in a large school.

School hours are another aspect of the organizational structure that can make it difficult for at-risk students who have to work as well as attend school. The way school hours are scheduled, usually from 8 a.m. to 3 p.m., leaves little flexibility for working students. Class scheduling can also be unrealistic. Classes are usually set up for 50-minute periods in high school, during which time students are expected to digest all of one subject matter such as math. The bell rings, indicating it is time to move on to the next class and subject. By the time the student returns to math, perhaps after missing class the next day because of an assembly, the concept of the math problem is lost and so is the student. How much better it would have been if the math problem could have been solved without the bell ringing. The point is that is most traditional schools, the organizational structure is not set up to encourage transfer of subject matter from one class to another. Teachers have little time to cross subject lines with other teachers in order to integrate information.

2. Procedural practices. Procedural practices are those practices and policies set up to ensure that the school runs smoothly and to protect the safety of students and staff. Rules and discipline fall under procedural practices. The problem with rules, with the exception of rules that protect the safety of others, is that they sometimes become more important than educating the student. It makes little sense to suspend a student who is skipping school, or to give a failing grade to a student who, for some understandable reason, is having difficulty with a subject. The disciplinary action does little to solve the problem. Such rules do not help the at-risk student, and may convey the message that no one really cares if he or she does succeed. There should be consequences for not following school rules, but rules should not be designed to infringe on educating the student. At-risk students are the ones who suffer most from inflexible, unrealistic discipline policies regarding attendance, tardiness, and dress codes.

3. Instructional strategies. Unfortunately, limited or inflexible instructional strategies and poor pedagogy harm even the most gifted students. Students may have different learning styles. A curriculum that is designed to fit a singular teaching style rather than diverse student learning styles can be detrimental, especially for the at-risk student. A curriculum that is based on seat time rather than competence can also be a barrier for students who need more time to work at a slower pace. Lastly, a curriculum that is meaningless and disconnected from the student's out-of-school life can result in boredom and disengagement from school. Some of the brightest students have dropped out of school due to boredom and lack of challenge.

4. Educational inequity. Educational inequity is the most difficult of the system factors to assess. Yet, it is probably the factor that harms at-risk students the most. Expectations that are lowered because a student is from a particular ethnic background or because the student is poor serve as an injustice. Some teachers treat poor students differently from middle-class students, believing that poor students are not as capable as those from more affluent families. The same holds true for Black, Hispanic, and Native American students. Students who are made to feel that they are not valued are more likely to drop out. Ironically, these students may not have suffered from low self-esteem until they were put into a situation where little was expected of them. It is only when a student begins to question his or her self-worth that insecurities and low self-esteem are created. When students' social class and ethnicity are accepted by other students, teachers, and school counseling staff, they will be much more likely to feel good about themselves and succeed. In the case of minority groups, this is more likely to happen if teachers and counselors are from the same ethnic background.

Aside from staff attitudes and expectations that are difficult to detect and change, a more obvious type of educational inequity is placing at-risk students in programs that fail to equip them with a full education. Some alternative programs may do an excellent job of building a comfortable shelter for the damaged student, but may put the student in jeopardy if academic goals and expectations are drastically lower than those for students in the traditional school. At-risk students may later feel they have been cheated by alternative education because they are still unequipped to work and survive in mainstream society.

The school system that is committed to helping at-risk students and educating its entire population will attempt to restructure itself in order to meet the needs of all students. The role that counselors play in this reformation stage is crucial because counselors may know the multiple needs of students better than anyone else in the building. Counselors need to act as visionary guides who instill hope for the future in students, and as student advocates within the school system. The entire system, however, will need everyone's creative leadership and a lot of collaboration to alter those changeable school factors that contribute to student dropout.

In summary, the main advantage of the systemic approach is that the school and its staff become ultimately responsible for the educational and related needs of students. Students are treated on an equal basis, with high but realistic expectations and goals being the norm for *all* students. The school system works cooperatively with social service agencies without, however, *becoming* a social agency. Schools try to adapt to the needs of students rather than the needs and convenience of the bureaucracy. Our society has thrust upon schools the difficult but not impossible challenge of becoming more flexible for a diverse population without lowering educational standards. The challenge is to apply the research on at-risk students toward restructuring the system to better meet their needs. What is not often recognized is that this approach not only works to the advantage of the potential dropout but also is good education for all students.

Conclusions

The placement of this chapter near the end of the book is fitting because, as we have shown, the problem of school dropout involves many of the personal, family, and social issues discussed in previous chapters. We have stressed several main points throughout this chapter that are summarized below.

First, school dropout is a serious problem that eventually harms both the personal lives of young people and our society. Counselors must help students realize that the easy choice to leave school is not necessarily the best choice in the long run. Young people who do not complete their high school education often feel deep regret later in life. As our society and economy change, dropouts will find it increasingly difficult to lead productive and satisfying lives. Second, there is no single type of dropout nor a single magic pill that will help all of those who are at risk of leaving school. In addressing this multifaceted problem, counselors must assess many aspects of student functioning, including what is going on outside of school life, to develop effective interventions that address the whole student. Third, school counselors are an important link to families and community agencies whose help may be needed to deal with the whole student. Likewise, community counselors need to coordinate their services with schools. The fourth and final point is that schools need to be more sensitive to the needs of students through more responsive structuring, scheduling, programs, and policies. Counselors can be effective advocates for at-risk youth in school committees and other forums to ensure that schools recognize and respond to the needs of a diverse student clientele.

The role of the counselor in helping potential dropouts should be, first, to give sound guidance to students who are already experiencing problems and establish primary prevention programs for all students. Second, counselors should play the role of communicator between students and school staff, parents, and community agencies, working to build a climate of caring and respect. For students who are disengaged from school or feel that they are being treated unfairly, caring and respect are needed before any counseling intervention will take effect. Third, the counselor should be an advocate and friend to students who may feel lost or shuffled from teacher to teacher in large schools. Teachers may feel responsible only for part of the student, that is, for student learning in a specific subject area. Counselors are in a better position to deal with the whole student and provide continuity throughout the student's school career, especially in large schools that are often very chaotic places.

Most high school counselors would probably agree that supportive guidance and counseling can help at-risk students have a more positive and productive school experience, especially those students who lack support in their home setting. Counselors are often responsible for helping students make decisions about their educational direction. In most cases, a counselor's daily routine will be more involved with scheduling and dealing with behavior problems rather than working as a team with teachers and other staff to develop holistic solutions. Student problems are too often addressed piecemeal in schools.

Districts that buy into the systemic approach realize that counseling is a valuable component of the total educational system. In addition to providing guidance and day-to-day assistance with discipline, counselors should be full partners in developing and implementing programs designed to increase student academic and personal success. Administrators must define a larger role for counselors. Along with this larger role, counselors must receive adequate training in program development and in organizational and advocacy skills. Districts must support this expanded role by establishing lower student-to-counselor ratios so that counselors have the time to be involved in school-based and district-based decisions. Districts should consider more counseling services in the elementary grades so that early problems can be identified and dealt with more effectively.

In the movement to reshape education, much research has been done to describe and understand the dropout problem, but little has been said in the discussion about the importance of school guidance and counseling. School and community counselors are too often underutilized resources in helping at-risk youth. Counselors can be major contributors to the success of students who experience problems in school. As the movement to improve schools continues, an expanded role for school and community counselors needs to be considered.

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Chapter 15

THE SOLUTION LIES IN PROGRAMS THAT WORK

Walter Hathaway, Carolyn Sheldon, and Patrick McNamara

The problem of educating at-risk students is not new. In past years, the labels used for at-risk students have differed, but the problems of students who do not complete their high school education, are unable to obtain jobs upon leaving school, and become burdens to their families and society have been part of the American educational scene since comprehensive schooling began.

Who are these students at risk? There is no set pattern. Some are brilliant but bored; others have low ability and are undersupported or deterred by their home situation. Some are emotionally troubled, abused, on drugs, or prematurely pregnant; some are male and some are female; some are wealthy but most are poor. Some come from Bill Cosby's TV family, some from my family or your family. And some have no family at all—at 12 years of age or even earlier, they are on the streets, alone.

The changing demographics of the United States indicate increased growth of the groups with the highest school failure rates. The percentages of poor and minority children in America are rising swiftly—from 17% of the population in 1985 to twice that projected by the year 2025 (Committee on Economic Development, Research and Policy Committee, 1987). This trend, combined with the increasingly complex demands of the workplace, has created a situation demanding immediate action by our schools and communities.

That action is being taken in many places around our nation in the form of successful programmatic responses to the challenges of students at risk.

Almost two thirds of all our nation's poor children are White, but African and Hispanic American children are much more likely to be poor and educationally disadvantaged than White children (Committee for Economic Development, 1985).

Let's look at some statistics (Duncan & Rodgers, 1985; Hathaway & Kushman, 1988; U.S. House of Representatives, Select Committee on Children, Youth & Families, 1987):

- Forty-three percent of African American and 40% of Hispanic children are poor.
- African American children are nearly three times as likely to be poor as European American children.
- The national dropout rate for minority students is 50% or higher, versus an average of less than 20% for nonminority students.
- Minority students are often far behind on achievement measures. The Southern Regional Education Board reports, for example, that on national assessment tests, the reading achievement levels of Black 11th-grade students are basically the same as for White seventh graders.
- In 1988 African American students' SAT mathematics and verbal scores were 106 and 92 points lower, respectively, than those of White students. Hispanic American student scores were also substantially lower.
- African American students are approximately three times as likely to be in a class for the educable mentally retarded, but only half as likely to be in a class for the gifted and talented as White students.
- African and Hispanic American students are two to three times as likely to be suspended or expelled and only half as likely to be enrolled in courses that lead to a college education.

In a review of the research, Kushman and Hathaway (1988a) noted that students may be at risk for:

- Performing below potential in school;
- Becoming alienated from school;
- Dropping out of school;
- Failing to get a job, or being employed below their potential; and
- Becoming a drain on society rather than a contributing member.

The symptoms or predictors of dropping out or of being at risk include:

- Poor and deteriorating attendance;
- Behavioral problems;
- Low achievement;
- Premature pregnancy;

- Poor self-esteem;
- Lack of realistic life goals related to schooling; and
- Poor study and learning skills and habits.

Some correlates of dropping out or being at risk include:

- Low family income level;
- Low family educational level;
- Membership in a minority group;
- Emotional difficulties;
- Abuse; and
- Chemical dependency.

The heterogeneous nature of the at-risk population necessitates varied approaches to meet each individual student's unique needs. The reasons why some youth do not succeed in school and life are as numerous as the individuals themselves. The interplay of these reasons adds to the complexity of the problem (see Figure 1). Figure 2 shows some of the factors that can interact to help these at-risk students succeed. The main purpose of this chapter is to profile model programs that have proven successful in reducing or eliminating the causes of failure for students at risk so that counselors and other key service providers can emulate and replicate those successes in their own settings.

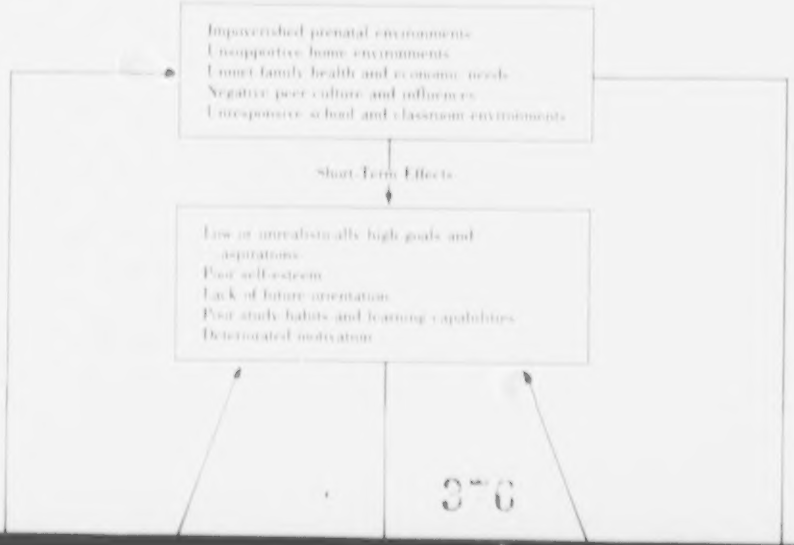
The major characteristics of successful programs for students at risk are well known. In its cover story entitled "Save the Children," (Whitman, 1988), *U.S. News and World Report* summarized them as follows: "The ingredients of successful programs for disadvantaged children are no secret. Typically, they provide a wide range of services, have dedicated staffs that work intensively with clients, involve parents and community groups, and aim, where possible, to help preschoolers" (p. 44).

Even though the broad outlines of the characteristics of successful programs for students at risk are well known, there are no easy answers to the specific problems of educating students at risk. Because many of the most promising programs have been initiated only in the past few years, there is little evidence available on the effectiveness of these efforts.

The previous chapters in this book have outlined some of the numerous causes of the problems of at-risk students and have described approaches to prevention, intervention, and remediation of these problems. This closing chapter will describe the general standards of program evaluation, give the specific criteria we used in identifying successful programs for at-risk students, and provide some illustrative examples of programs that work according to those criteria.

FIGURE 1

Model of Factors of Failure for Students At Risk


Impoverished prenatal environments
Unsupportive home environments
Unmet family health and economic needs
Negative peer culture and influences
Unresponsive school and classroom environments
Short-Term Effects
Low or unrealistically high goals and aspirations
Poor self-esteem
Lack of future orientation
Poor study habits and learning capabilities
Deteriorated motivation

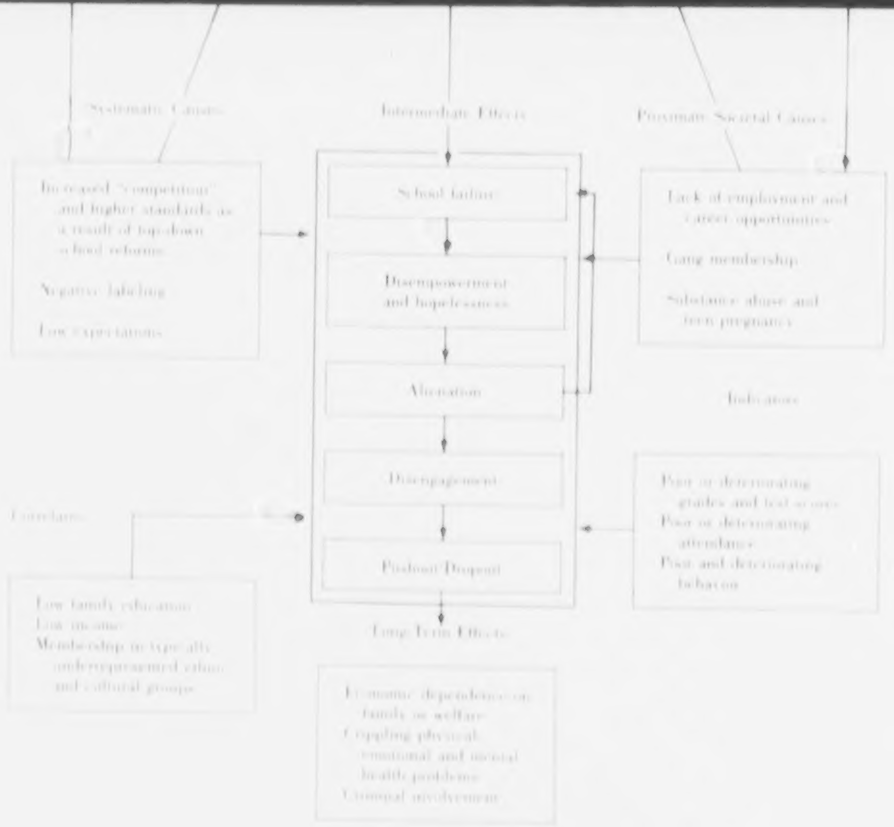
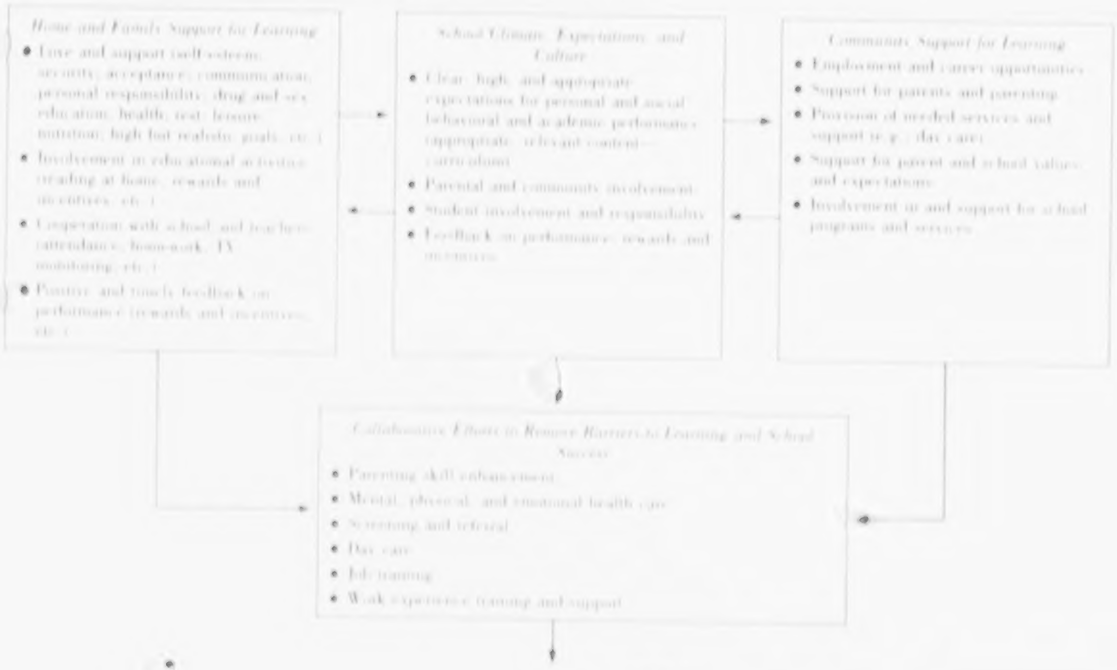
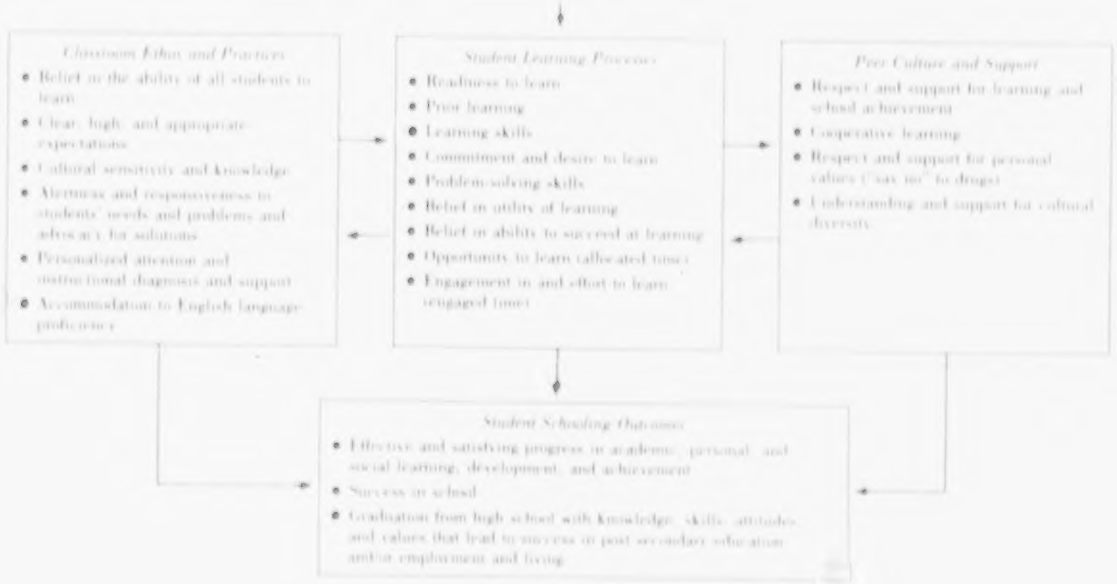

Systematic Causes
Intermediate Effects
Proximate Societal Causes
Increased "competition" and higher standards as a result of top-down school reforms
Negative labeling
Low expectations
School failure
Disempowerment and hopelessness
Alienation
Disengagement
Pushout/Dropout
Lack of employment and career opportunities
Gang membership
Substance abuse and teen pregnancy
Indicators
Poor or deteriorating grades and test scores
Poor or deteriorating attendance
Poor and deteriorating behavior
Correlates
Low family education
Low income
Membership in typically underrepresented ethnic and cultural groups
Long-Term Effects
Economic dependence on family or welfare
Crippling physical, emotional and mental health problems
Criminal involvement

FIGURE 2

Model of Factors of Success for Students At Risk


Home and Family Support for Learning
Love and support (self-esteem; security; acceptance; communication; personal responsibility; drug and sex education; health; rest; leisure; nutrition; high but realistic goals; etc.)
Involvement in educational activities (reading at home; rewards and incentives; etc.)
Cooperation with school and teachers (attendance; homework; TV monitoring; etc.)
Positive and timely feedback on performance (rewards and incentives; etc.)
School Climate, Expectations, and Culture
Clear, high, and appropriate expectations for personal and social behavioral and academic performance (appropriate, relevant content—curriculum)
Parental and community involvement
Student involvement and responsibility
Feedback on performance; rewards and incentives
Community Support for Learning
Employment and career opportunities
Support for parents and parenting
Provision of needed services and support (e.g., day care)
Support for parent and school values and expectations
Involvement in and support for school programs and services
Collaborative Efforts to Remove Barriers to Learning and School Success
Parenting skill enhancement
Mental, physical, and emotional health care
Screening and referral
Day care
Job training
Work experience training and support


Classroom Ethos and Practices
• Belief in the ability of all students to learn
• Clear, high, and appropriate expectations
• Cultural sensitivity and knowledge
• Alertness and responsiveness to students' needs and problems and advocacy for solutions
• Personalized attention and instructional diagnosis and support
• Accommodation to English language proficiency
Student Learning Processes
• Readiness to learn
• Prior learning
• Learning skills
• Commitment and desire to learn
• Problem-solving skills
• Belief in utility of learning
• Belief in ability to succeed at learning
• Opportunity to learn (allocated time)
• Engagement in and effort to learn (engaged time)
Peer Culture and Support
• Respect and support for learning and school achievement
• Cooperative learning
• Respect and support for personal values ("say no" to drugs)
• Understanding and support for cultural diversity
Student Schooling Outcomes
• Effective and satisfying progress in academic, personal, and social learning, development, and achievement
• Success in school
• Graduation from high school with knowledge, skills, attitudes, and values that lead to success in post secondary education and/or employment and living

General Standards of Effective Program Evaluation

Although it is difficult to assess objectively and conclusively the exact value of a program, general standards for program evaluation can be applied to assess the worth of programs for students at risk (Joint Committee on Standards for Educational Evaluation, 1981). These standards include criteria used to determine the utility, feasibility, propriety, and accuracy of program evaluation.

Utility standards of program evaluation include: audience identification; evaluator credibility; appropriate scope and selection of program effectiveness information; clear description of the perspectives, procedures, and rationale used to interpret that information; clarity and comprehensiveness of reporting; appropriate and timely sharing of results; and planned follow-through. Feasibility standards include: practicality and minimal disruptiveness of the evaluation procedures; political viability; and cost-effectiveness. Propriety standards include formal commitment to participation in the evaluation and responsiveness to its findings; identification and removal of any conflicts of interest; assurance of the public's right to know; protection of the rights and dignity of the participants; balanced, accurate, and fair reporting; and fiscal responsibility in using the resources dedicated to evaluation. Accuracy standards include: clear description of the treatment whose effects are being evaluated and of the relevant contextual factors; adequate delineation of the purposes and procedures of the evaluation, including the evidence used and its sources; appropriate information gathering; systematic quality control of the data and their analyses; justification of the conclusions in terms of the evidence; and freedom from bias.

These general standards of good program evaluation should be applied when assessing the worth of programs for students at risk.

Criteria for Evaluating Successful Programs for Students at Risk

We have identified and highlighted some successful efforts in the remainder of this chapter. The success of these programs has been determined by the application of a set of criteria including, but not limited to: (a) evidence of effectiveness in attaining the program's mission and goals gained through appropriate evaluation and monitoring; (b) comprehensiveness of the services offered; (c) relevance to post-school student goals; (d) cultural sensitivity; (e) community involvement in planning and implementation; (f) clarity of the program's objectives and their integration with the goals of the district educational program; and (g) the collaborative nature of the program, with planned interactions among parents, students, teachers, administrators and support staff, and community and business representatives. The remainder of this chapter presents the results of the application of these criteria both through a survey of the nation's largest school systems and through a review of the evaluation literature on national and local programs.

Results of a National Survey on Successful Programs for At-Risk Students

In January 1988, the Portland (OR) Public School District's Department of Research and Evaluation conducted a survey of 114 directors of research and evaluation from the largest school districts in the United States and Canada (Hathaway & McNamara, 1988). A total of 83 responses were received to this questionnaire, which asked about districts' definitions of students at risk and requested information about formal policies, plans, and programs for identifying and serving students at risk and about procedures for monitoring the effects of efforts to meet these students' special needs. The districts were asked to provide specifics on these issues, and many documents accompanied the completed questionnaires. The following two sections summarize the survey responses and provide a brief analysis of the material that accompanied the responses.

Definitions

Just as with the term "dropout," there seemed to be no agreed-upon definition for the phrase "students at risk." The definitions ranged from the most typical response of giving lists of student at-risk "characteristics" or "contributing factors," to the occasional broad projections of what students may be at risk for.

In the definitions provided by the responding districts, the most common characteristics of students at risk were: (a) poor attendance, (b) retention in grade or school failure, (c) low standardized test scores, (d) older than classmates, and (e) family background. Other factors frequently mentioned were: (a) student is a parent or is pregnant, (b) discipline problems, (c) lack of interest in school, (d) minority status, (e) behavioral problems, and (f) limited English proficiency.

One district returned this sample definition that identifies common characteristics of students at risk: "Students were defined as at-risk based on four types of information: (a) if they had achievement scores below the 41st National Curve Equivalent (national 33rd percentile); (b) if they were one or more years below average performance on standardized test scores; (c) if they were in danger of failing on a structured teacher report; (d) or had risk factors external to school (e.g., return from court placement, pregnancy, abuse, etc.)."

A review of the program descriptions submitted with the surveys did lead to the identification of some innovative and promising programs based on the following criteria: the number and types of students reached were specified; comprehensive coordination of programs was indicated; community involvement in the planning process was evident; periodic monitoring and evaluation were planned; multilevel (home, district, cluster, school, community) solutions were envisioned; a long-range vision of success was articulated; and evidence of demonstrated effectiveness was provided.

Highlights From Some Exemplary Programs

The Detroit and Cincinnati public school districts both reported collaboratives that involve educators, business leaders, parents, students, government and community organizations, clergy, law officials, and media in planning and overseeing dropout prevention efforts. These collaboratives have hired staff to coordinate all program components that address problems of students at risk. The Detroit Prevention Collaborative has a 5-year strategic plan and the Cincinnati Youth Collaborative has an initial 3-year plan; both plans address the problems of at-risk students in preschool through 12th grade. Because both are in their early stages of implementation, as yet there are no documented demonstrated effects.

The Tucson Unified School District also has a model collaborative. Tucson focuses on lowering dropout rates in middle and high schools. The collaborative consists mainly of educators, with some involvement of students, parents, and business leaders. The district personnel coordinate the programs.

The Eugene (OR) School District and the Scarborough School District in Ontario, Canada, have early identification programs that assess the special needs of newly enrolled students in their districts. The Eugene district has a mandatory questionnaire filled out by each student or parent upon a student's entry into the school system. If any three of the six questions on the questionnaire are answered affirmatively, the student is labeled at risk, and special provisions are made for that student's education. The Scarborough district has an "Early and Ongoing Identification Project" that identifies "a child's learning strengths and weaknesses in order to maximize success and minimize failure." This project is required by the Ministry of Education for all Ontario schools. All parents of students entering the Scarborough district are shown a filmstrip and audiotape that explain the early identification project and make parents more aware of their children's educational needs.

Other districts having especially innovative strategic plans for serving at-risk students are those of Milwaukee, Seattle, Norfolk, and Portland. Milwaukee implemented a "Plan of Service for Children At-Risk" in the 1987–88 school year, which uses the district's database to identify students in grades 8–12 with specific at-risk characteristics. The district contracts with agencies in Milwaukee addressing the problems of at-risk students, and has a management team composed of representatives from the contracted agencies and district personnel to monitor the success of programs. Seattle founded a 39-member "Disproportionality Task Force" in August 1985 with the goal of eliminating disproportionality in all aspects of education by 1989–90. The task force, made up of educators and representatives from legal, ethnic, and community organizations, made recommendations to the school board on how best to eliminate disproportionality. Norfolk Public Schools initiated a school improvement plan called SPIRAL, which has been effective in reducing dropout rates by 43%, increasing retention rates in grades 1–6 by 12%, decreasing expulsions, and raising standardized test scores in its first 4 years of operation.

The Portland (OR) School District also has a variety of successful programs for students at risk, including a comprehensive process for identifying the needs of students at risk and for gaining cooperation among parents, students, teachers, administrators, business and community representatives, and policymakers in planning and carrying out improved programs and services for students at risk. Several of Portland's specific programs are profiled in the following section.

Profiles of Successful Programs for Students at Risk

In addition to conducting the national survey described above, we have reviewed the literature on effective programs for students at risk (Kushman & Hathaway, 1988a, 1988b) using the criteria described earlier and have selected the following programs as having demonstrated exceptional effectiveness. We have noted the target population, the special features, the counseling/mental health component, and the demonstrated effectiveness of each program as well as a key contact person.

1. *Program: Middle College High School, Long Island City, NY*

Target Population: 10th, 11th, and 12th-grade students who have had at least 20% absenteeism in the ninth grade, are about 1 year behind grade level in academic achievement, or come from disadvantaged homes.

Special Features: The students are admitted directly from junior high school. The admissions committee consists of the principal, school counselors, and selected graduating seniors. There are over 600 applicants for each entering 10th grade class of approximately 200 students.

The school is located on the LaGuardia Community College campus. The high school students are encouraged to use the college facilities and take college courses for credit.

Students work in internships for one third of the school year. Flexible schedules and self-paced classes allow for accommodation of student needs and development of responsibility. The total size of the school (500 teachers), as well as class sizes of 20 students or less, allows teachers and administrators to supervise students closely.

Counseling/Mental Health Component: There are daily group counseling sessions of 10–12 students led by 4 full-time counselors. The issues for discussion range from personal/psychological to drug, alcohol, and family problems.

Demonstrated Effectiveness: The cost per student is the same as that in a regular New York City school of similar size, about $5,400. Middle College High School has an 85% graduation rate. Three fourths of its students go on to college.

Besides these statistics, the location of the high school on a college campus adds to its effectiveness for the at-risk students it serves. The setting gives students a realistic picture of college and adult life as well as the accompanying responsibilities and expectations.

Contact: Celia Cullen, Principal, Middle College High School, Long Island, NY 11101.

2. *Program: Guaranteed Services Counseling and Guidance Program, Santa Clara Unified School District, Santa Clara, CA.*

Target Population: K–12th grade. This program serves all students in the district, K–12. Some students are specifically referred if they are identified as being at risk of dropping out, or have already done so.

Special Features: Because the program serves all district students, very few, if any, are allowed to slip through the cracks.

There is an elementary, middle, and high school component to the program, with specific services for each grade level consistent with the particular needs of that age group.

Students are not treated in isolation from their total environment. The areas of service span a variety of needs: orientation and registration; educational and career planning; testing; communication with parents and students; and individual and group counseling.

The Guidance Services Calendar, which is designed and implemented by each individual school, is an essential component of the Guaranteed Services Counseling and Guidance program. This calendar ensures that services are available at the appropriate time to meet the needs of the student population of each school.

Counseling/Mental Health Component: A counselor works directly with each student, planning a program that will best meet his or her needs, and serves as a resource person for parents, teachers, administrators, and school staff who work with students.

Demonstrated Effectiveness: The Guaranteed Services Counseling and Guidance Program has had remarkable success since it was implemented in the Santa Clara schools. In a November 1988 evaluation report on this program as adopted and implemented in Portland, 82% of those students responding to a survey reported that they were satisfied with the counseling help they received. In the same year, 91% of teachers responding to survey questions reported satisfaction with the counseling services (Leitner, 1988).

One aspect of the program, which allows for annual reassessment and restructuring if necessary, is the yearly evaluation by the district administrators. This ensures that students and parents are given the best resources possible to meet their unique needs.

The Santa Clara program has served as a model for other guaranteed service programs througout California and the United States. Its success is due, in part, to its not being a static, externally implemented program, but a dynamic effort that first assesses and then designs to meet the unique needs of a district and its individual schools.

Contact: Gene Unger, Director of Secondary Education, Santa Clara Unified School District, 1889 Lawrence Road, Santa Clara, CA 95051.

3. Program: The Portland Investment, Portland, OR

Target Population: At-risk youth ages 12–21, defined primarily as those whose success is impeded by any of the "barriers to success" developed by the Leaders Roundtable, a group of key leaders from government, education, business, industry, religion, and the community (Leaders Roundtable, 1987).

Special Features: This is a comprehensive plan to provide education and employment related services to at-risk youth. Specifically, the purpose of the Portland Investment is to reduce youth unemployment, reduce dropout rates, enhance academic achievement, and improve the academic, social, and economic prospects of Portland's youth.

There are 13 programs under the auspices of the Portland Investment. This multifaceted approach to meeting the multiple needs of at-risk youth recognizes the diverse problems that lead to being at risk. The subprograms and their intended purposes are:

A. *Bridge*—To help at-risk 14- and 15-year-old students make a successful transition from middle to high school;

B. *Career Awareness Related Education (CARE)*—To keep high school juniors and seniors in school until they graduate or obtain a GED;

C. *Career Pathways*—To assist low-achieving high school juniors and seniors from low-income families with their academic performance in order to improve their opportunities for college admission or a job upon graduation;

D. *Financial Services Academy*—To provide employability skills and experience in the financial services field;

E. *Partnership*—To help minority and disadvantaged high school sophomores develop basic and vocational skills that will help them obtain a job upon graduation;

F. *Registry*—To recognize, reward, and motivate through mentorships, scholarships, and job opportunities high school sophomores who show potential for success;

G. *Summer Teen Employment Program (STEP)*—To assist 14- and 15-year-old at-risk youth to reduce achievement losses in reading and math during summers, to decrease teen pregnancy, and to lower dropout rates;

H. *North Portland Student Services Center*—To help students' attendance and academic performance through increased involvement of social service agencies in the school life of children;

I. *Comprehensive Summer Youth Employment Program*—To assist youth to obtain a diploma or GED and provide them with the skills to establish long-term employability;

J. *Teen Parents Program*—To encourage and assist teen parents and pregnant teens to obtain a diploma or GED;

K. *Frontier One*—To help 12–17-year-old youth who have experienced legal, behavioral, and academic difficulties find the best place for themselves, in or out of school;

L. *Outside In*—To provide preemployment skills, attitude enhancement, and basic necessities to at-risk street youth; and

M. *Youth Employment Institute (YEI)*—To provide 16–21-year-old youth with job skills and employment.

Counseling/Mental Health Component: Seven of these programs offer direct counseling services, and the others refer youth to services as needed.

The Targeted Services Specialist for the Portland Investment Plan works individually with each student to determine specific needs and provide a link to the programs that will best meet those needs.

Demonstrated Effectiveness: Although some component programs of the Portland Investment have been operating for some time, the coordinated effort has existed only since 1987. There has not yet been a comprehensive evaluation of the whole effort. A descriptive evaluation of the Portland Investment was done, however, in July 1988. This evaluation was highly favorable and has resulted in the Portland Investment becoming a national model for broad collaborative school/community efforts to improve and coordinate support for students at risk.

Contact: Linda Kelley, Private Industry Council, 1704 N.E. 26th Ave., Portland, OR 97212.

4. *Program: Early and Ongoing Identification Project, Ontario, Canada*

Target Population: All students in the public schools in Ontario, Canada. The parents of all students entering the Ontario schools are interviewed to determine their child's academic and personal needs. The students' educational programs are then designed to reflect the identified needs of each individual student.

Special Features: By early and ongoing identification of a particular student's needs, the school is able to develop a personalized program of instruction that avoids problems that might develop later in that child's educational career.

Although not specific to at-risk students, the Early and Ongoing Identification Project will catch the students who have at-risk characteristics, and by doing so may avoid the problems associated with school failure and dropping out.

Counseling/Mental Health Component: If a particular problem is identified that requires more than ordinary classroom resources, support staff are provided to work individually with students. The Ontario schools will, with parental permission, refer students to nurses, psychologists, psychiatrists, social workers, or other support staff.

Demonstrated Effectiveness: Because all students in Ontario are required by law to participate in the Early and Ongoing Identification Project, there is no control group against which those in the project can be compared. The Ministry of Education for the Ontario Province gave the project positive reviews, citing improved communication between school and parents as one positive result.

Contact: Assistant Deputy Minister of Education Programs, Ontario Ministry of Education, Mowat Block, Queen's Park, Toronto, Ontario M7A 1L2 CANADA.

5. *Program: Positive Alternatives to School Suspension (PASS), Portland, OR*

Target Population: High school students with behavioral and discipline problems.

Special Features: The PASS program provides school staff with an alternative to out-of-school suspension for secondary students with discipline problems. Whereas out-of-school suspensions interrupt the learning sequence of students who may already be having difficulties, and possibly increase the risk of students dropping out of school, the PASS program provides positive, structured resolutions to the problems that frequently lead to suspension and expulsion.

Three main strategies are employed in the PASS program: (a) Conferencing—provides students who have experienced discipline problems with a better understanding of themselves through counseling, and an increased ability to anticipate and avoid future problems; (b) Time-out—gives students a time to "cool off" for one or two class periods before returning to their regular classes; (c) In-house suspension—provides a structured, on-site environment for students during their suspensions, so as not to interrupt the students' learning sequence.

The components of the PASS program ensure a balanced and holistic approach to student discipline. The four components are: (a) *Student:* peer counseling, clarification of school expectations, classes that prepare students to deal realistically with their world, tutoring, and personal advising and counseling; (b) *Staff:* staff awareness of PASS program, monitoring of classwork during time-out or in-house suspension, multicultural sensitivity training and resources, classroom visitation, and additional referrals; (c) *Parent:* parent conferences on their child's behavior problems, regular contact with parents on child's status, and additional referrals; (d) *Community:* guest speakers and community resources available for specific problems.

Counseling/Mental Health Component: In all schools with PASS programs, group as well as individual counseling is available. Such counseling is done by the PASS coordinator. As a preventive strategy, counseling is the first recommendation in all schools. Counseling focuses on attitudinal changes related to discipline and behavior. In one PASS school, resources are focused on drug and alcohol counseling. Regular school counselors are available for consultation as often as needed. These counselors play an important role in coordinating and implementing the PASS program.

Demonstrated Effectiveness: The staff of PASS schools report that they appreciate the program. It offers them alternatives to traditional disciplining strategies. Two of the three schools where the program operates, however, reported an increase in out-of-school suspensions since the PASS program began (Grice, 1986).

In interviews with school staff where PASS programs are operating, the consensus is that the program has had a positive effect on school climate. Less violent behavior had been reported, and teachers feel better able to resolve conflict without the help of support staff. The disproportionality of minorities being disciplined also has decreased in PASS schools.

Contact: Coordinator, Discipline Programs, Student Services Department, Portland Public Schools, Child Services Center, 531 S.E. 14th, Portland, OR 97214.

6. *Program: Project SOAR (Student Opportunity, Advancement, and Retention), New York City, NY*

   Target Population: 9th- and 10th-grade students absent at least 20 days in the semester previous to admission or retained a grade because of low academic achievement. Specifically targeted are limited English proficiency and special education students.

   Special Features: Project SOAR is an alternative school environment within a regular high school setting. Classes and individual tutorials in English, math, science, and social studies are offered. The goals of the project are to improve attendance and achievement and increase retention.

   Besides special classes, students in Project SOAR receive dental, vision, hearing, and health services, group and individual counseling, and cultural and recreational field trips. Close contact is maintained with students' homes; this includes home visits, regular teacher-parent conferences and phone calls, plus school functions and workshops for both parents and students.

   Counseling/Mental Health Component: Intensive group and individual counseling is an integral part of Project SOAR and is required for all participants.

   Demonstrated Effectiveness: For those students participating in Project SOAR for a full school year, the program has proved effective. Attendance was improved and about half passed at least one more class than they had the previous year.

   Contact: Bernard Wolinez, Chief Administrator, Office of High School Support Services, New York City Schools, 362 Schermerhorn Street, Brooklyn, NY 11217.

7. *Program: Summer Training and Education Program (STEP)* (Initiated and managed by Public/Private Ventures (1987) in five school districts: Boston, Fresno, San Diego, Seattle, and Portland)

   Target Population: Disadvantaged youth 14 and 15 years old who have experienced low academic achievement, are at high risk of teen pregnancy and parenthood, and are eligible for the Federal Summer Youth Employment and Training Program.

Special Features: STEP encourages at-risk youth to complete their schooling and graduate by addressing two main causes of dropping out: low academic achievement and teenage pregnancy. The program operates during the summers and provides students with (a) minimum wage, part-time summer jobs; (b) remedial math and reading education; (c) life-skills training; and (d) reasonable social and sexual behavior training.

During the school year, the program reinforces the goals and gains made during the summer through ongoing contact with students by the STEP advocates. This is augmented through personal counseling, group social and educational activities, and parental contact.

Counseling/Mental Health Component: Personal and group counseling is available in most STEP programs. It is particularly emphasized during the intervening school year as a means of follow-up and ongoing adult support.

Demonstrated Effectiveness: The results are encouraging. During the summer, when non-STEP youth lost about a full grade level in reading and a half grade level in math achievement, STEP youth lost an average of only one third a grade level in reading, and actually gained a third of a grade level in math. STEP students were also less likely to fail or be absent, reported gains in self-esteem, participation in school activities, better attitudes and performance in school and jobs, and were one and a half times more likely to use contraception than were sexually active non-STEP youth (Public/Private Ventures, 1987).

Contact: Public/Private Ventures, 399 Market Street, Philadelphia, PA 19106.

8. *Program: Project Return, Portland, OR*

Target Population: Students who have dropped out of or are chronically absent from school. Three methods are used for referral: (a) administrative referral based on eight unexcused half-days within a 20-day period, (b) parental referral, and (c) self-referral.

Special Features: The Project Return staff assesses each referral and plans the appropriate response. Contact is then made with the student by phone to further assess the student's individual needs and causes of truancy. An interview at the student's home or at the project office follows the phone contact, and provides further information on the student's potential to return to some educational program.

If students cannot immediately enter the school or alternative program that has been jointly determined to be appropriate, they are placed in the "transition classroom." This provides the students with an opportunity to complete coursework they had not previously completed because of irregular attendance, and to set a pattern of regular attendance. It also allows the school to test and evaluate the student's achievement level.

After a period of up to 60 days in the transition classroom, an exit plan is designed for each student, in which goals for attendance and academic achievement are set. Once the student begins the school program, the Project Return staff monitors that pupil's attendance and provides instructional support.

Counseling/Mental Health Component: Personal and group counseling is availabile to students through the services of a counselor assigned to the project. The counselor also facilitates the transition of students into high school programs by planning with the receiving high school staff and monitoring student progress.

Demonstrated Effectiveness: Middle school truancy was reduced by 10.6% during the second year of the program; and it was found that the earlier in the year that students were identified, the better the chance for sustained reenrollment. The use of the "transition classroom" concept seems to have minimized the loss of students caused by placement delays as well as reduced costs by avoiding second and third efforts at processing a student (Grice, 1987).

Contact: Aleena Boozer, Administrator of Alternative Education, 6318 S.W. Corbett, Portland, OR 97201

Conclusions and Implications for Action

Our report on the at-risk programs of 83 large city and county school systems in the United States and Canada revealed that many districts are working to reduce the dropout rates by identifying at-risk individuals and providing special programs and assistance for them. Most programs are so new that it is difficult to determine just which strategies are the most successful at keeping students in school and helping them succeed in school and in life. (Hathaway & McNamara, 1988).

Some of the more promising programs involve many members of the community, including business leaders, parents, educators, and even the media. The development of these collaboratives requires that diverse elements of the community work together to help provide a better future for at-risk students and society as a whole. Such mobilization of the whole community is one extremely important step that should be addressed by anyone developing an at-risk program. The statistics found throughout this book and its references, especially those on the future costs of continued failure to address the needs of students at risk, should motivate such collaborative efforts. Many businesses have already found that it is more beneficial for them to invest money in school programs than to donate money to colleges (Bailey, 1988). By investing in school programs, business and industry help to ensure the existence of employable graduates with requisite skills. Using the media is also an excellent idea; television, radio, and newspapers reach many people who might be interested in improving their community and thus better the quality of their lives. It is an important part of the role of at-risk program directors to involve the community.

Another important role of program directors and their staff is to secure funding for these programs. Even the best programs cannot succeed, or even proceed, without dedicated individuals and adequate funding.

Our survey also revealed that programs for students at risk that work tend to have certain common characteristics, although not every successful program exemplifies all characteristics in the same way. Some of the common characteristics of successful at-risk student service programs are:

- Using multiple approaches to reach heterogeneous populations;
- Being flexible;
- Working with other agencies in a coordinated fashion;
- Being sensitive to concerns of the population(s) being served, (being culturally sensitive and addressing the specific problems of at-risk populations);
- Including employment training;
- Including life skills training;
- Identifying students at risk early;
- Involving the entire community (including youth service agencies, businesses, government and other student, parent, and community representatives); and
- Treating each student as an individual and as a complex, whole person.

Well planned, supported, and executed evaluation is another essential ingredient for a successful program. There should be both formative and summative evaluation of programs. Formative evaluation is extremely important for keeping any program on track and responding to the needs of those being treated. If something is not working, it is better to find out early and change it than to continue because "that's what we originally planned to do." Another reason for regular evaluation is to contribute to decisions about future funding. The funders of programs, whether governmental or private, need to see that their support is getting results.

Summative evaluation is also important to give specific information about the overall success of programs in attaining their goals. Any evaluation process should follow the Standards for Evaluations of Educational Programs, Projects, and Materials (Joint Committee on Standards for Educational Evaluation, 1981). The areas to be evaluated should be closely related to the original (or adjusted) goals of the program. Evaluation criteria and procedures should be determined at the same time that the goals and objectives of the program are established—this will help to prevent biased evaluation procedures.

A final important aspect of evaluating programs for students at risk that can help to ensure success is embracing the points of view of all the major stake holders: students receiving services, those providing the services, and the community, parents, business, and so forth.

Our nation is founded on the belief that every individual is of great worth. The sacrifice of any individual's potential is therefore a loss of tragic proportions. Thus, it is a moral as well as an economic disaster when even a single student at risk succumbs to the risks and drops out of school only to drop in on society later as a crushing burden.

Saving students at risk makes enormous practical as well as moral sense. We can make a modest investment to help now, or we can pay a terrible price later. The Committee for Economic Development, as quoted in Smith and Lincoln (1988), found that for every $1.00 we now invest to identify and help students at risk early in their school careers, we can save $4.74 in costs of remedial education, welfare, and crime further down the road.

Failure to meet the needs of students at risk is thus not only a tragic human waste, but also a mortgaging of the future of our society and our children. By rising to meet this challenge, we can create a more humane society in which all individuals are empowered to reach their full potential and thus become contributing members of the community. It is our hope that research, ideas, processes, and solutions set forth in this chapter and this book will help us all work together to create more successful responses to the problems of at-risk youth.

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